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5

TRANSACTIONS

OF THE

DERMATOLOGICAL SOCIETY

OF

GREAT BRITAIN AND IRELAND

EDITED BY

GEORGE PERNET, M.R.C.S.

AND

WILLIAM T. FREEMAN, F.R.C.S.

1898–9

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1898—99.

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RULES

OF THE

DERMATOLOGICAL SOCIETY

OF

GREAT BRITAIN AND IRELAND.

(REVISED 1896.)

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1. *Object of the Society.*—The object of the Society shall be the improvement of knowledge in all subjects relating to Diseases and Symptoms displayed by the Skin.

2. *Constitution of the Society.*—The Society shall consist of Ordinary and Honorary members. All legally qualified medical men shall be eligible as ordinary members.

3. *The Officers.*—The officers of the Society shall consist of a President, four or more Vice-Presidents, a Treasurer, two Secretaries, a Librarian, and twelve other members, who together shall form the Council and manage the Society's affairs.

4. *Election of Members.*—Candidates shall be proposed on a form provided for the purpose, and signed by three members from personal knowledge. The names of those proposed as new members shall, in the first instance, be submitted to the consideration of the Council, with whom the power shall rest of declining to allow the nomination to proceed. The proposal paper shall be read at one Ordinary Meeting, and the Ballot shall be taken at the following Meeting. No election shall take place unless ten members vote, and no person shall be elected who does not obtain four-fifths of the votes given.

5. *Form of Admission by the Chairman.*—Members shall be admitted personally by the following form, after signing their names in the Admission Book, and paying their first Annual Subscription:—

> FORM OF ADMISSION.—"*By the authority and in the name of the Dermatological Society of Great Britain and Ireland I admit you a member thereof.*"

6. *Honorary Members.*—The Council shall have the power of proposing men of distinguished eminence in Dermatology, or in the sciences bearing upon it, for election as Honorary Members. The number of Honorary Members shall never exceed ten. They shall be elected in the same manner as Ordinary members.

7. *Expulsion of Members.*—The Council shall have the power of removing any name from the members' list, and shall, if it think fit, deem the following offences against professional good taste as justifying such a course:—The issue of books or papers on medical subjects addressed to the public; the advertisement of medical works in non-medical journals; the giving of testimonials which may be used for advertisements. Any member who may have received notice of the Council's intention to remove his name, may, if he think fit, appeal to the Society, whose vote, under Rule 8, shall be final.

8. *Appeal.*—A member who appeals against the decision of the Council can be finally expelled only at a General Meeting specially called for that purpose, and of which a written notice shall have been sent to every member at least fourteen days previously. At least ten votes must be recorded, and four-fifths shall carry the expulsion.

9. *Subscriptions.*—The Annual Subscription shall be One Guinea, payable in advance at the date of the Annual General Meeting. Each member on election shall pay an Entrance Fee of One Guinea in addition to the Subscription, but in the case of a member elected at a meeting of the Session subsequent to Easter he shall not be required to pay a Subscription during the next Session. Any member whose Subscription is six months in arrear shall be reminded of the same by one of the Secretaries, and if it be not paid within the current year he shall cease to be a member. Any member may, at any time, pay a Composition Fee of Fifteen Guineas and be thereby exempted from paying any further Subscriptions, such member enjoying all the

same rights and privileges, and subject to the same penalties, as if he were a Subscribing member. Any member resident out of the United Kingdom may pay a Composition Fee of Seven Guineas instead of the Annual Subscription, and will then be entitled to receive, post-free, a copy of the Society's "Transactions" each year, and to have his name printed in the list of members; but if at any time he subsequently become a Resident in the United Kingdom, the question of further payment by him shall be decided by the Council.

10. *Election of Officers.*—The officers of the Society shall be elected yearly by Ballot at the Annual Meeting, to which all the Ordinary members shall be summoned one week before. No gentleman shall hold the same office for more than three consecutive years. Balloting lists of the names recommended by the Council for election shall be sent to each Ordinary member, together with the notice of the Annual Meeting.

11. *Scrutiny of Ballot.*—Two Scrutineers appointed by the Chairman at the commencement of the Annual Meeting shall receive the lists during the first hour, and report the result to the Chairman. In the event of equality of suffrage, the Chairman shall determine.

12. *The President and Vice-Presidents.*—The President shall regulate all the proceedings of the Society and Council, state and put questions, interpret the application of the Rules, and decide any doubtful points. He shall check irregularities, and enforce the observance of the Rules. He shall sign the minutes of all meetings of the Society or Council. In the absence of the President, one of the Vice-Presidents, the Treasurer, or some other member chosen by the Meeting, shall perform his duties.

13. *The Secretaries* shall conduct all correspondence, shall attend every meeting of the Society and Council, and take minutes, which shall be read at the following meeting. They shall notify to new Members their election. They shall arrange with the President the order of proceedings at the meetings. They shall have charge of, and keep a register of, all Papers communicated, and shall be the Editors of the "Transactions."

14. *Clinical Secretaries.*—In addition to the two Secretaries, the Council shall at its discretion appoint one or more members of the Society under the title of Clinical Secretary, whose duty it shall be to take cognisance of all patients brought for demonstration, and to record and classify in books kept for the purpose the notes of their cases. Whenever practicable, these notes are to be completed by subsequent applications to the member who brought the patient.

15. *The Treasurer* shall receive all moneys due to the Society, and make all payments ordered by the Council, keeping an account of all such receipts and payments. He shall keep printed receipt-books for Entrance-fees and Subscriptions, and every receipt and cheque shall be signed by himself and countersigned by one of the Secretaries. He shall present to the Annual Meeting a written report of the financial state of the Society, signed by himself and by two members of the Audit Committee. All moneys shall be banked in the name of the Society.

16. *The Librarian* shall have entire charge and control of the Library. He shall, as opportunities arise, purchase books for the Library at his discretion out of the grant previously voted for this purpose by the Council. He shall see that all books belonging to the Society are duly entered in the Catalogue, and that the periodicals and pamphlets are from time to time, as occasion may require, suitably bound. It will be his duty to see that the Library Rules are not infringed.

17. *Audit Committee.*—The President, one of the Secretaries, and two members of the Society nominated by the President at some meeting of the Society previous to the Annual Meeting, shall form a Committee to audit the Treasurer's accounts.

18. *Council Meetings.*—The Council shall meet half-an-hour before or after the meetings in October, January, and May, and before the Annual General Meeting, and at such other times as it may be specially convened. Three shall form a quorum. The Council shall determine questions by show of hands (or by Ballot if demanded), the President having in both cases a casting vote in addition to his ordinary vote. They shall have the power of filling up any vacancies which may occur in any of the offices of the Society between one Annual Meet-

ing and another. They shall decide upon all questions relating to the reception of communications and to their publication in the Society's "Transactions."

19. "*Transactions.*"—The "Transactions" shall be published annually, and sent free to all members of the Society.

20. The *Ordinary Meetings* shall be held from 5 to 6.30 P.M. on the fourth Wednesday in October, November, January, February, March, April, and June. If the day fixed should fall on the Wednesday before Good Friday, no meeting shall be held. The Society's rooms shall be open half-an-hour before each meeting, for the informal exhibition of patients and preparations.

21. *Annual Conference.*—A Conference shall be held in May, on a day to be appointed by the Council. The objects of the Conference shall be the demonstration of patients, and such Discussions and Papers as the Council may deem suitable.

22. *Annual Meeting.*—The Annual General Meeting of the Society shall be held during the Conference, when the Annual Reports of the Council and Treasurer shall be read.

23. *Visitors.*—Each member may introduce as visitors, at an Ordinary Meeting, two gentlemen, on entering their names in the attendance book.

24. *The business of the Ordinary Meetings* shall consist in part in the exhibition of patients, drawings, and card specimens, and in part the reading of Papers. The former half of the meeting shall, when there is material present, be devoted to the first-named object, and the reading of papers will follow.

25. *Communications.*—Communications shall be taken in the order in which they have been sent in to the Secretaries, subject to the discretion of the President. If an author be not present when the time arrives for his communication to be read, it shall be dealt with as the President may direct.

26. *Papers.*—All papers must be sent to the Secretaries at least one week before the meeting, and become the property of the Society. An abstract suitable for immediate publication in the journals should

accompany each paper. All reports of papers, discussions, or other proceedings of the Society intended for publication shall be made through one of the Secretaries.

27. *Discussion of Rules, &c.*—Nothing relating to the Rules or management of the Society shall be considered at the Ordinary Meetings.

28. *Alteration of Rules: Procedure.*—Any member proposing an alteration of the Rules, must give written notice of that alteration to the Secretaries, not less than three weeks before the Annual Meeting.

29. *Alteration of Rules: Annual General Meeting.*—At the Annual General Meeting proposed alterations of Rules shall be considered and decided upon, notice of such alterations having been given in the summons convening the meeting. Ten shall form a quorum at this meeting, and for the adoption of any alteration of the Rules four-fifths of the votes given must be in its favour.

30. *Special General Meeting.*—A Special General Meeting may be called at any time, on one week's notice, by the President, or at the request of any ten members, the nature of the business being specified in the summons sent to each member of the Society, and no other business being considered.

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TRANSACTIONS

OF

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

THE THERAPEUTICS OF DISEASES OF THE SKIN.

BEING THE INTRODUCTORY ADDRESS DELIVERED AT THE ANNUAL MEETING OF THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND, ON MAY 26, 1898.

BY H. RADCLIFFE-CROCKER, M.D. (LOND.), F.R.C.P. (LOND.),

President of the Society; Physician to the Skin Department, University College Hospital.

GENTLEMEN,—In taking the chair for the first time of a society like this it is natural that you should expect from me a few introductory remarks, first as your new President, and secondly upon the subject on which we are to meet together in order to extend our knowledge of it, and to promote its study.

I cannot but esteem it as a compliment that you should have invited me to succeed to such distinguished members of our profession as Dr. Pye-Smith and Dr. Payne; and I am fully sensible of the responsibility thus involved. I cannot expect to hold the torch of knowledge higher, or make it burn brighter than my predecessors, but at least no efforts shall be wanting on my part, so that if its light shall not wax, at least it shall not wane in my hands.

A President however can do little without the cordial co-operation of the members of the Society, and it is this co-operation which I

trust you will give me, both for your own sakes, as it will help forward Dermatology, and for mine, as it will much lighten the load of responsibility.

I propose now to address a few remarks to you on the subject of the *Therapeutics of Diseases of the Skin*, and to ask you to review with me some of the principal improvements which have been made in the last twenty years, and the grounds upon which those improvements have been based, as they will probably show the direction in which we must study to make further advances.

I desire, therefore, not to bring before you new drugs or new dressings, but rather to discuss the principles which must underlie our practice if we desire to be scientific practitioners and not mere empirics.

The time has long gone by when arsenic can be considered a panacea for almost all cutaneous woes, and that men should pin their faith to this or that formula because some well-known authority has given it his imprimatur.

Empirical discoveries have been made, and doubtless will be made from time to time, of more or less value, but a science of art which depends upon haphazard discoveries is but little likely to make much real progress.

The only sound foundation for building up a reliable superstructure in Therapeutics depends on our improved knowledge of the Pathology of the skin affections which we have to treat, and in no part of the body can we study the pathology of disease so advantageously as on and in the skin.

Both the anatomy and bacteriology of skin lesions can be studied in the living subject, an immense advantage which rarely presents itself for lesions of other organs. Our chief difficulty in the bacteriology of the skin is in the number of different organisms which appear to be always present, and it is therefore troublesome to isolate, and prove which is the true pathogenic organism of the disease we are investigating. Difficulties however are seldom insuperable, and no class of diseases has benefited by improvements in bacteriological methods of investigation more than those of the skin.

At the same time what has been done is a mere drop in the ocean to what remains for investigation, and there is no more promising field for young workers than the bacteriology of diseases of the skin.

Great care must, however, be taken not to confound secondary microbic invasion for the primary one—a source of fallacy often very difficult to avoid, yet, when made, capable of doing infinite harm by leading men's minds in a totally wrong direction.

Leaving, however, what the future has in store for us, let us look back a little and count some of the therapeutic gains which the new pathology has brought in its train.

Let me take as an example such a thing as a common boil. It is not very long ago when the pathology of a boil was a complete mystery, and was regarded only as an example of the inscrutable ways of Providence. Some thought boils were the effect of too high living, and kept their patients down with restrictions on their diet and their alcohol; others that they were a sign of vital depression, and kept their patients up with port wine, tonics, and improved hygiene. There were a few empirical remedies, such as sulphide of calcium and the administration of yeast, which, it is true, were not without benefit in some cases, but of their *modus operandi* no one had the slightest idea, and their inadequacy for the removal of the complaint was only too frequently evident, while the pernicious practice of poulticing each boil was universal, and is still only too prevalent. When the discovery came that boils were due to the introduction of the almost ubiquitous staphylococcus aureus and its brethren albus and citreus into the follicles of the skin, then not only did what was a mystery in its etiology before now become clear, but the path to treatment was distinctly pointed out, and we now know that the persistent local disinfection of each boil, either before or after suppuration, is not only the best for the boil then present, but if carried out on each fresh boil as soon as it appears will, before long, exhaust the supply of the pus cocci and lead to the cure of cases which had previously defied treatment for weeks, months, or even years. This is so true that we may tell the patient, with all the positiveness of the irresponsible quack, that we can cure him, and with the additional satisfaction that we know we can keep our word. What is true of boils is true of all the skin diseases due to this same organism, carbuncles, impetigo contagiosa, and its variant ecthyma, coccogenic sycosis and some other forms of folliculitis, pemphigus neonatorum, the purulent complications of ordinary eczema and of some other less defined suppurative diseases of the

skin, all yield, and that speedily, to the destruction of the organism which produces diseases so morphologically dissimilar, but of which the variations are readily explicable, as they are dependent on the anatomical distribution in the tissues of the pathogenic agent. As a result, while the aim is the same in all, we have to resort to different methods to get it—viz., the destruction of the pus cocci which set up the inflammation.

This direct destruction of the morbific agent is, however, only one method of preventing the malign influence of micro-organisms. Whenever the surface of the skin is disturbed by inflammatory or other lesions it is liable to be invaded either from without by various cocci or bacteria, or from the skin itself where it is probable that of the many organisms always present apparently inert, some at least only await a favourable opportunity, such as a state of inflammation, to take on pathogenic characters.

One of the most serious examples of secondary invasion of the skin by micro-organisms from without is the multiple gangrene of children which is liable to follow varicella, vaccinia, and other vesiculo-pustular eruptions of infancy. While their exclusion is rarely thought of in these otherwise trivial diseases, the destruction and control of the gangrene exciters can often be successfully obtained by measures similar to those used for carbuncle, although we are not certain that the organism is the bacillus pyocyaneus, or some other equally dangerous.

The recognition of this secondary invasion is of special importance in the treatment of chronic eczema, and explains the *modus operandi* of the tar-baths first put forward by Hebra, which yield such remarkably good results in cases of long standing when used with intelligence and discretion; but I must pass on to consider some points of the internal therapeutics of diseases of the skin.

We may ask, however, does our increased knowledge of the influence of microbes derived from without on diseases of the skin, render all the views of our forefathers on what used to be called humoral pathology absolutely obsolete and worthless? I do not think so. There is still a place for consideration of abnormal blood states, though not so large a one as was formerly assigned to it. Only we must read the lesson somewhat differently. It has been well observed that there is not so much importance in the meeting of the

man and the microbe as in the condition of the man when the rencontre takes place. There are certain conditions which undoubtedly favour the development of recognized microbic diseases, and which must be taken into account in our treatment of these diseases. Thus Diabetes mellitus is a well-known predisposing cause of boils, carbuncles, and abscesses; and gout, while its influence in predisposing to various forms of dermatitis has been greatly exaggerated by the profession in the past, and by the laity at the present time, is by no means to be despised as an etiological factor, and even in such a disease as syphilis dormant tertiary symptoms are often awakened by a gouty state.

Other examples might be cited, but on this part of the subject I do not propose to dwell to-day.

The great success attending upon a more intelligent local treatment, which began when Hebra's strong hand swept away the cobwebs of the old theories of impurities of the blood and the fantastic ideas of malign diathetic influence of the older French school, led to such a reaction that the German school and its followers in other countries practically abandoned internal treatment except as regards arsenic, and to them the skin was an organ separate from the rest of the body as far as practical therapeutics were concerned. The objective was everything, the history of the malady and the constitution of the patient almost disregarded, and seldom inquired into, and what began as a healthy scepticism of old theories was in danger of becoming a morbid agnosticism which almost disdained further enquiry. I am speaking chiefly of those who studied dermatology, for to the mass of the profession dermatology was only a farrago of names, and gout stood as the *fons et origo* of all inflammatory troubles, and tubercle and syphilis explained the rest, and the therapeusis was simple and futile accordingly.

To the extreme localists, the effect of an animal extract, like that of the thyroid gland on the skin, must, to the more thinking minds, have come as a shock as well as a surprise.

Although, no doubt, it has disappointed the too sanguine expectation of some of the enthusiastic early workers with it for some diseases, yet there is a good, solid residuum, viz., that here is a substance which undoubtedly exercises a marked effect upon the nutrition of the skin as well as other tissues in certain morbid

states, and it is only reasonable to infer that thyroid extract does not stand alone in this respect, not only as regards those found in the animal but probably in the vegetable and mineral kingdom also, and is it not our duty and our interest to try to find them?

Haphazard inquiries, however, are seldom successful; we must therefore seek some principle to guide, or some analogies which may help us. We have seen, very briefly, how much good was obtained by antisepsis, either by a scientific application of microbicides to skin lesions, or by excluding morbific microbes, or by putting the skin into a position to resist their attacks.

Cannot similar effects be obtained on similar principles by internal remedies? No doubt the difficulties are greater, and the results often less immediately obvious, yet there are facts to encourage us, and which show that something has already been done in this direction, and much more may be done.

Surely the intramuscular and intravenous injection of mercury and its salts for syphilis is not uninstructive in this direction.

No doubt the peculiarities of practice, especially of private practice, in this country, offer difficulties which are little felt on the Continent, where they are so extensively used, and no doubt there are certain inherent drawbacks to both methods, such as the painfulness of the intramuscular injections and occasional dangerous salivation, and the frequent occurrence of thrombosis from intravenous introduction of the drug. But at least they show this, that a serious disease like syphilis may be successfully combated by this method, and often more readily than by any other; moreover, recent observation has shown that syphilis is not the only disease which may be favourably influenced by these methods. Leprosy, psoriasis, some forms of lupus, etc., may also be favourably modified, or even sometimes removed by them. Not only mercurial salts, but other drugs or substances may yet be found, and should certainly be looked for, which will produce as good or better results, and who that has seen the effect of carbolic acid injected subcutaneously round a carbuncle can doubt that such a search will certainly be crowned by success?

And yet another direction in which we may search on well-grounded hope. There are a few diseases of the skin which we know are due to a bacillus or coccus circulating in the blood or deposited in the

tissues; for example, leprosy, tuberculosis, and glanders. There are many more in which we may fairly conjecture their presence in the blood as pathogenic factors. Can we in any way get at them by internal remedies? Surely we can sometimes do so by giving drugs which we know break up in the circulation and set free substances which have a microbicide action. Our task would be easier, but that we must take very good care that we do not liberate a too potent agent which we cannot control, and which may damage the host as well as its parasite; but already we know of a few such substances, and further research will no doubt bring others to light. I will mention now only salicin, which sets free salicylic acid in the circulation, and ichthyol, which sets free sulphur, and the last-mentioned substance furnishes another example of a sterilisation of skin products from within. Thin has shown that that revolting affection, bromidrosis of the feet, was due, not to the secretion of foul sweat, but to the decomposition of the sweat after excretion by the bacterium fœtidum, and that local antiseptics, such as boric acid, would prevent this decomposition; it does not however prevent the excessive secretion. Now it has long been known that sulphur internally both prevents the smell and diminishes the excess. Knowing, as we do, that sulphur is eliminated by the skin when taken internally, it is no great step to infer that it practically sterilizes the sweat by preventing the growth of the bacterium fœtidum after the excretion of the fluid.

Already, then, we have a few drugs that have a definite and a potent result in the directions I have indicated, and it should not be long before we add to their number. In addition to animal extracts and drugs, another door is opening to us in the shape of toxin serums. It is true that tuberculin and Coley's fluid have disappointed us so far; but, temporary as the limited success of tuberculin has been, it is enough to show that further enlightened research may discover some toxin with more permanent beneficial action in some diseases other than those due to tubercle. The effect of erysipelas on some diseases of the skin is very encouraging in this direction. In Lupus vulgaris or erythematosus the effect of an attack of erysipelas is often most striking. I have seen large areas clear up under its influence, leaving a healthy, thin and pliable cicatrix. The same is true in tertiary syphilis, most obstinate gummatous and other lesions are cleared off in the most marvellous way by erysipelas; and for a last example, the

only exception to the uniformly fatal result in that formidable disease Mycosis fungoides is a case which recovered permanently after an attack of erysipelas.

I have myself known of one case in which an attack of double pneumonia with a high temperature cleared off nearly all the lesions of Mycosis fungoides for a long time, but what we require is more control over the action of erysipelas toxin, lest we raise a spirit which we cannot lay, when he has done our bidding, and it is not too much to hope that bacteriologists will give us such a controllable serum before long if we ask it of them.

I have by no means exhausted all that could be said as to still other directions in which results already gained encourage us to work on, but I will not detain you longer, as there is much before us to-night. I trust, however, I have said enough to show that there is plenty of scope and numerous indications for further investigation on scientific lines, both for external and internal remedial measures, and that every gain in our knowledge of pathology will probably be a stepping-stone for improvements in therapeutics.

May 26th, 1898.

THE Annual General Meeting and Conference of the Society was held on Thursday, May 26th, 1898, Dr. J. F. PAYNE, President, in the Chair.

The Report of the Council and the Treasurer's Statement having been passed, the Ballot for Officers for the Session 1898-99 took place, and resulted in the following gentlemen being elected:

President: H. RADCLIFFE-CROCKER, M.D.

Vice-Presidents: ROBERT L. BOWLES, M.D.; A. J. HARRISON, M.B., J.P.; JONATHAN HUTCHINSON, F.R.S.; J. F. PAYNE, M.D.; PHILIP H. PYE-SMITH, M.D., F.R.S.; BUXTON SHILLITOE, F.R.C.S.; WALTER G. SMITH, M.D.

Treasurer: JAS. HERBERT STOWERS, M.D.

Hon. Secretaries: GEORGE PERNET, M.R.C.S.; WILLIAM T. FREEMAN, F.R.C.S.

Council: F. H. BARENDT, M.D.; WALLACE BEATTY, M.D.; H. A. G. BROOKE, M.B.; JOHN CAVAFY, M.D.; ALFRED COOPER, F.R.C.S.; A. EDDOWES, M.D.; T. COLCOTT FOX, M.B.; JAMES GALLOWAY, M.D.; EVAN H. HARE, F.R.C.S.; E. C. PERRY, M.D.; CHARLES H. THOMPSON, M.D.; HENRY WALDO, M.D.

After a cordial vote of thanks to the retiring President, Dr. H. RADCLIFFE-CROCKER took the Chair and delivered his Presidential address, which will be found on page 1.

The following cases, drawings, etc., were then shown:—

Dr. PAYNE showed (1) a girl, æt. 7, the subject of *Morphœa* on the left arm, left shoulder, left side of the face, and left thigh, which she had had for some years, and had been treated for in various hospitals. She was now a patient at St. Thomas's Hospital, and he thought there had recently been some improvement. As usual in such cases, besides the white parchment-like parts, there were hyperæmic areas with dilated vessels. The hand was very stiff, and the fingers could not be straightened or flexed completely. The elbow joint was also stiff. There was nothing in the history explanatory of the origin. It had

been progressive to the present time, but now seemed to be arrested. Lanolin had been rubbed in and the arm and neck had been massaged every day. She had also had opium in small doses gradually increased. The patient was now taking ♏ v. three times a day. It seemed to dilate the vessels of the skin and keep up the circulation through the arterioles, having an effect somewhat like that in chronic ulcers of the leg.

(2) A man, æt. about 60, from the Skin Hospital, Blackfriars, who for four years had had a most intense irritation of the skin. It would be observed that there was a thickening of the skin, more particularly on the limbs, and most marked on their extensor surfaces, consisting of an agglomeration of papules; it had never been vesicular. Looking at its anatomical characters, they would be inclined to call it lichenous, but it was not Lichen planus, or the Lichen acuminatus of Hebra. He would therefore be glad to hear what name should be given to the condition. It was not prurigo in the ordinary sense, because it commenced late in life; the irritation was the most striking feature of the case. The chief question was whether the lesion of the skin was primary, or merely a consequence of irritation and scratching.

(3) A boy with *Prurigo*. He had had an eruption of some kind since he was two months old. At that time the eruption was said to have the character of eczema, but was always accompanied by most intense itching. No doubt it began as Lichen urticatus, or infantile prurigo, and that as a result of the scratching eczema supervened, but it seemed now to be passing into a condition of true prurigo. There was a pale papular eruption, with thickened skin, and enlarged lymphatic glands in various parts of the body.

Dr. Radcliffe-Crocker showed (1) a man, æt. about 50, the subject of an iodoform eruption. He said he thought the case would be somewhat *apropos* on that occasion, as drug eruptions were to be discussed. The case was sent to him by Dr. Corner as an instance in which dermatitis followed the local application of iodoform. The patient had had several accidents, and each time his wounds were dressed with iodoform, and he had a more or less extensive dermatitis as a consequence. The present eruption began about a fortnight ago following an injury to the back of the hand, on which iodoform

powder was applied at the London Hospital. When he (Dr. Crocker) saw the patient three days ago there was a congeries of minute vesicles or pustules thickly arranged, as could still be seen. The inflammation was not limited to that part, but affected both hands, his neck, and testicles, thus showing lesions far beyond the point of application. The effect must, he thought, be due to absorption of the iodoform. No doubt the present patient was hypersensitive to the drug. The inflammation was subsiding now, but the patient had not had any local treatment for the last three days, and the eruption was subsiding. There was nothing special to recognise in the form of the dermatitis to connect it with the drug; it looked like simple inflammation of an eczematous type.

(2) A patient, of about 40 years of age, with an eruption which began as an ordinary case of eczema, and for which he had been under treatment for a considerable time. He was the subject of aortic disease, and the eczema had been very troublesome, but within the last month it had cleared up in parts, and left gyrate lines on the skin very much like those observed in psoriasis, only much less scaly. In connection with eczema the feature was unfamiliar to him. He had not examined the scales for micro-organisms, for in such a case so many would be present that the difficulty would be to isolate any one and identify it with the condition.

Dr. A. J. Harrison showed photographs of an interesting case which came under his notice at the Bristol General Hospital. The patient had suffered from a hairy tumour or nævus all her life, and some few years ago she began to develop fibrous tumours—Molluscum fibrosum—in various parts of the body, some of which increased very much in size. One in particular, on the left hip, became very irritative, and she was admitted to the hospital surgically for operation upon this tumour. The photographs showed that nævoid growths now occupied nearly the whole of the body, with patches on the arms, face, and legs, descending even down to and involving the feet and ankles. They could be seen over the right eyebrow, on the right cheek, and then there was very extensive degeneration of the skin, and thickening of the skin from the back right away to below the knees. The skin of the body was simply thickened and dark, and below the pubes and about the thighs it was very hairy, looking remarkably like the skin of a gorilla. As far as he could ascertain, the condition was congenital, and there was a history that when her mother was in the seventh month of pregnancy a horse fell dead and alarmed her very much, and that was looked upon as the starting point of the peculiarity. Of course the probability of this being the cause was doubtful; anyhow it proved coincidental. There was a family of eight children, but none of the other members of it were similarly affected; nor was there any ancestral history. It was the most extensive case of "hairy nævus" he had ever seen.

Dr. STOPFORD TAYLOR showed water-colour drawings and coloured photographs of the following cases:—

(1) A seafaring man who came under his care six years ago suffering from Lupus erythematosus of both cheeks and nose, and an epithelial growth of the lower lip.

Exposure to a tropical sun was the presumable cause of the lupus. The growth was excised, and the patient was not seen again until a few days ago, when he returned for treatment of a similar growth on the lobe of the nose.

(2) Lupus vulgaris of both cheeks, forehead, and nose, with a rodent ulcer beneath the right eye. The lupus was treated with the thyroid extract and subsequent linear scarification, and the ulcer excised.

(3) A case of very extensive Lupus erythematosus of thirty years' standing in a glass-blower from St. Helens. The disease involved the whole of the face and scalp. An epithelioma was situated over the left malar bone.

(4) A woman with numerous seborrhœic warts studded all over the body. An epithelioma had developed from one situated on the right flank.

(5) A man with a severe rodent ulcer of seventeen years' standing, excavating the whole of one side of the face.

Dr. STOWERS said he wished to make a remark on one of the excellent series of pictures lent for the meeting by Mr. JONATHAN HUTCHINSON, viz., factitious gangrene of the face. It suggested to him a case which was under his observation some years ago, and which he saw with Dr. Sangster. A young woman was admitted into hospital with a number of superficial abrasions, which after a time became somewhat gangrenous, not nearly so marked as in the picture, but sufficiently so to show that the whole structure of the skin was involved. It was suspected that she had applied some chemical agent, and strict watch was kept over her, but in spite of this fresh sores appeared. One of the Resident Medical Officers suggested that wetting the finger and applying friction would produce similar sores. This was done, and an admission was obtained from the patient that such had been her course of procedure.

Dr. J. H. STOWERS then read the following paper entitled:

DRUG ERUPTIONS: THEIR NATURE AND VARIETIES.

As we have been already reminded, we meet to-day to inaugurate a new Session. The object of our Society, as set forth in the Rules, is "the improvement of knowledge in all subjects relating to diseases of, and symptoms displayed by, the skin."

The area of study thus included is a wide one, so extensive, in fact, that it embraces every department of medicine and surgery. Wherever the healing art is exercised attention must constantly be devoted to disorders and diseases of the skin, directly or indirectly produced.

The subject of drug eruptions, which has been selected for consideration to-day, is one that is more or less familiar to us all.

While the few may have greater opportunity of studying them, for the reason that more special practice, both hospital and private, affords a larger field of observation, yet the many—the majority of our members—occupied as they are in the practice of general medicine and surgery, have no inconsiderable opportunity of witnessing the effects of the innumerable therapeutic agents in daily use.

In accepting the invitation of our late president to open the discussion, I am not unmindful of the fact that to treat of the nature and varieties of drug eruptions in a short paper in anything like completeness is impossible, besides which, an individual experience of the subject must necessarily be far too limited to allow the inclusion, from personal knowledge, of all the many eruptions which may be produced by medicaments. However, while thanking him and the Council for the favour conferred upon me, which I fully appreciate, I can only attempt to give a very brief *résumé* of the subject, drawn chiefly from the writings and observations of others, as well as the narration of a few cases of special interest which have been under my own care.

The scientific study of drug eruptions is of comparatively recent date. Our text-books on materia medica and therapeutics, with a few exceptions, make but slight reference to them, and the majority of these include but a few of the best known or commonest varieties. Morrow, of New York, in his excellent book—the most complete, I believe, which has yet been published on the subject before us—states that Lorry, of Paris, "was the first dermatologist who called attention to the production of eruptions from the use of drugs in a treatise published in 1777. Subsequently Bell, of London, in 1796, Alley, of Dublin, in 1804, Montègre, in 1814, Rayer, in 1835, Ricord, in 1842, Devergie, in 1857, and Bazin, in 1862, have followed in the same direction, and more recently many observers in England, America, France, Germany, Austria and other countries have studied and written upon this important subject.

As would be expected, there is no single definition of drug eruptions which has been universally accepted; indeed, the term is occasionally used in a somewhat different sense by various writers. By some the influences of direct or external contact are omitted, and only those included in the list which follow internal administration. By others all evident and manifest changes in the skin, whether produced by

actual and external contact, or by internal administration (*i.e.*, by the mouth, the rectum, the genito-urinary system, inhalation, or subcutaneous injection—in fact, every channel connected with absorption and elimination), are included in the group. By others, again, as Morrow states, the term "has been limited in its application to the anomalous or incidental effects of drugs upon the cutaneous surface in contradistinction to changes in the skin which are a more or less constant expression of the drug's physiological action, and which may be provoked for therapeutical purposes." The proper signification of the term embraces all congestive and inflammatory changes in the skin caused by the external or internal use of drugs.

In this definition every eruption due to outward application must be included, whether for medicinal, therapeutic, or commercial purposes, *i.e.*, connected with the various industries in which chemical and other agents are so largely employed, besides all those which result from the introduction of every kind of drug into the system by absorption through whatever structure or channel it may find entrance. If our definition is to be really inclusive and complete, we cannot omit the series of cutaneous manifestations which have been observed in connection with inoculation with attenuated virus, either of animal or specific origin, utilized for the conferring of immunity from, or for neutralizing the effects of, poisons or toxic products already introduced into the blood. And yet more recently we have recorded, though not strictly, perhaps, within the boundary, the effects attributable to the use of electricity for diagnostic or other remedial purposes which alter the nutrition and materially disturb the structure of the skin and appendages consequent upon the use of the Röntgen method, including the so-called X-ray burn.

Electrolysis, too, is sometimes responsible for consequences with which we have to deal. Self-inflicted injuries for the purpose of deception deserve a place in the group. Chloroform and ether inhalations are capable of producing remarkable changes of an eruptive character, of which I witnessed more than one example when anæsthetist at St. Bartholomew's Hospital, in 1873 and later. Recently, Dr. Dudley Buxton, among others, has written upon the subject.

All these are to be included in the ever-increasing list of thera-

peutic agents which exercise peculiar and obvious effects upon the cutaneous system.

Concerning *classification*, Bazin merely divided the group into two, viz. :—

1. Those produced by direct application upon the integument.
2. Those resulting from indirect administration or absorption.

Behrend went further, and classed drug eruptions as follows, viz. :—

1. Those occasioned by the specific action of a drug—acute in character.
2. Those caused by the elimination through the skin of certain drugs—chronic in character.
3. Eruptions caused by the dynamic action of drugs which are, like the first class, acute in their development and course, but appear to possess a certain period of incubation.

Dr. H. G. Brooke, of Manchester, read a valuable and instructive paper at the International Medical Congress at Berlin in 1890, in which he set himself to consider the etiology of drug eruptions. His special purpose was to deal with the question :—"Are the dynamic eruptions of Behrend to be separated completely from those which he considers specific?"

Brooke first refers to the fact that so many substances of "totally dissimilar chemical constitution" are able to produce one and the same exanthem. And again, that "the same substances produce in different individuals very different eruptions."

He points out the never-to-be-forgotten influence of idiosyncrasy as it exists in the individual, and discusses the suggestion of Behrend that "drugs do not produce their cutaneous phenomena by direct action, but through the agency of a limited number of chemical substances (now called toxines) which are engendered in the body under their influence."

By this hypothesis, says Brooke, "the number of the causes of drug eruptions are reduced, and, according to Behrend, the question becomes chiefly one of pathological anatomy."

He then proceeds to describe those drug exanthems which are chiefly angioneurotic in character, apart from those which are of inflammatory kind, and have the qualities of new growths.

In relation to those which are chiefly of nervous origin he admits the possibility of specific action (in the sense that Behrend uses the

term), if we study the influence of drugs upon the different functions of the nerves which supply the heart—digitalis for example—and recognize the uniform "selective action" they have on special nerves supplying it. In illustration of those drugs the action of which is less uniform and regular he mentions nicotine, "which, as we are aware, varies so much in its effect on different people."

Again, in a third group, he refers to drugs which are "so inconstant in their action that their effects cannot be anticipated."

In this idiosyncrasy is to be recognized. The larger number of the angioneurotic group, the manifestations of which are uncertain and irregular, depend upon the individual affected, quinine, chloral, and antipyrin being cited as examples. Whatever the varying eruptions may be in position, form, extent, duration, and degree they depend upon the particular structures involved, whether central or peripheral.

Brooke concludes by stating that he "does not discover any clearly defined differences between the specific and dynamic rashes of Behrend, but rather a continuous and gradually progressive series extending from those which occur with almost absolute regularity to those which vary in every individual." Neither, *per contra*, can he believe that "the limitations in the *modus operandi* of the drugs are completely accounted for by any special influence exerted on particular parts of the cutaneous nerve system."

So far as the vascular system is concerned in the process of production, he considers that "the general influence of all the drugs must be confined to the production of hyperæmia." "The cutaneous blood-vessels are embedded in a richly organized mass of tissue of extraordinary individual variety, thus explaining the strikingly different lesions which occur among the angioneurotic exanthemata. When a simple paralysis occurs we have a simple erythema which can, when the epidermis has little power of resistance, give rise to vesiculating and bullous erythemata; or, again, when a spastic element concurs, the erythematous basis may develop into papules like those of Erythema multiforme and nodosum, or into wheals; or, finally, where a passive condition (*Stauung*) takes the place of the active hyperæmia, purpura or œdema may be produced. All these different types depend not upon the constitution of the vascular and nervous systems, but upon the peculiarities of the skin itself, and

vary according to its individuality. The remaining number of the group in which (as in a quinine rash when a long-standing hyperæmia of more inflammatory kind with desquamation occurs) are explained by a local direct influence of the drug circulating in the blood on the tissues of the skin themselves over and above the angioneurotic influence of the nerve-centres" (Brooke).

Dr. Colcott Fox, who did so good a service in editing the reprint of Morrow's work for the New Sydenham Society in 1892, from which I have largely drawn, also contributed to the Berlin Medical Congress, in 1890, a valuable paper, directed more particularly to describe the consequences of the local application of certain drugs (such as iodoform, sublimate, belladonna, chrysarobin, &c.), deals with the important question:—"Are the widespread erythematous and vesicular eruptions arising from the above-named to be placed in the same category with the universal eruptions following the internal use of drugs?"

He reviews the writings of Köbner, Behrend, Atkinson, Van Harlingen, Morrow, Farquharson and others, and discusses the subject under the following heads:—

1. Effects strictly local, and limited to those regions with which the drug comes into contact, due directly to superficial local irritation, and occurring without any systemic reaction.

2. Effects also local, and due to peripheral action, but not coterminous with the site of application of the drug, and radiating for some distance around; occurring with or without systemic reaction.

3. Radiating effects due to more central irritation, with or without coincident systemic reaction.

In the first group he includes the substances which produce a local dermatitis (the dermatitis venenata of J. C. White of Boston, Mass., who has written exhaustively on this subject).

Fox specially mentions mercurial preparations, belladonna, chrysarobin, arnica, resorcin, and iodoform, besides other agents, as lime, sugar, &c., when there is no absorption.

In this connection I will mention an instructive case which occurred to me some years ago:—

A gentleman who had been under medical care for about a week with a limited urethritis of gonorrhœal origin, had diligently used a solution of permanganate of potash, both as a wash to the glans penis, and also for urethral injection. Rather earlier than the time when a primary chancre would have developed had he con-

tracted syphilis, he exhibited a raised indurated sore upon the preputial mucous membrane, of such questionable character that it was impossible, from appearance alone, to decide its nature. The use of the solution was continued, and a few days later he presented himself with two more sores, of equally uncertain nature, at the base of the glans. Their rapid development and unusually inflammatory character induced me to question him closely, especially as he admitted that he suffered severe pain on several occasions after the use of the lotion. It then transpired that he had prepared his own solution, and had used it with a small sponge before the crystals had dissolved, with the result that one or two adhered to the surface and had produced the sores complained of. Since then I have met with cases in which women have, with a Higginson's syringe, injected undissolved crystals of the same kind into the vagina for the treatment of leucorrhœa, and have produced severe inflammatory irritation.

In the second group, Fox describes the effects of iodoform, and Campbell Pope's experience (as reported in the *British Medical Journal*, April 6, 1889) are referred to, in which an "eczema-like" dermatitis attacked the whole limb on three different occasions when iodoform gauze, or ointment—separately used—had been applied for the treatment of an inflamed bursa of the arm. M. Savage, of Baltimore, in 1887* has recorded a similar case. Taylor, of New York,† has published a case in which the ethereal solution of iodoform applied to chancroids on the prepuce produced rapid swelling and inflammation of the whole penis. Marcus Beck had a similar experience after operation for removal of Scirrhus mammæ. Hebra, Tilbury Fox, Duhring, Cartier and others have reported similarly. At a meeting of this Society, held on the 26th of January last, and from which I was unavoidably absent, Mr. J. Hancocke Wathen, of Clifton, read a paper on "A Personal Reminiscence of the Local Effects of Iodoform."

He handled a dry preparation of iodoform gauze, having previously used the moist preparation. The same night he suffered great irritation of the hands. This was followed by blebs, mainly on the interdigital aspects of the fingers of the left hand, but some occurred on the interdigital webs of the right hand. The appearance and course of the eruption are said at first to have suggested Hydroa herpetiforme. Rest and appropriate dressings led to rapid recovery, but within three weeks a similar attack occurred, after using iodoform gauze, although upon this occasion it partook more of the characteristics of cheiro-pompholyx, with considerable dermatitis

* *Maryland Medical Journal*, Baltimore, 1887.

† *New York Journal*, 1887.

of the dorsal aspects of the hands. This occurred on two subsequent occasions, before he discovered that iodoform had produced the mischief. He narrated Mr. Jessop's (of Leeds) experience with the same agent, which corresponded exactly with his own. Mr. Pernet, Dr. Abraham, and Dr. Travers Smith spoke of having seen similar results. I have myself had under care several cases of the same kind.

In illustration of the 3rd group, Mr. Treves's case is narrated,* viz., that of a girl, in whom a wound was freely dressed with iodoform for three weeks. Subsequently the entire forearm became inflamed, and much febrile reaction followed in spite of the discontinuance of the drug. The rash spread to the face, neck, and chest, consequent upon absorption. C. J. Taylor, Janowsky, Wallich and others have described similar examples.

The forementioned are examples of T. C. Fox's first subdivision of the 3rd large group, constituting, in his own words, "the eruptions which begin locally from peripheral irritation and spread, and are followed by the evolution of remotely situated areas which may join together with the originally inflamed area to form a more or less generalized eruption."

His second subdivision, viz., "more or less widely-spread or generalized eruptions, beginning either near the site of application of the drug, or remotely in several places without local signs," is illustrated by the experiences of Zeissl, Janowsky, Hœpfl, C. J. Taylor, Berkeley Hill, Bolowski and others.†

Concerning the general characters of drug eruptions taken collectively, it is remarkable that all the lesions of the skin with which we are familiar may separately or together be produced, their development being gradual or rapid according to the many varying conditions which exist, such as quality and quantity of drug, mode of application, idiosyncrasy (general and local), conditions of health (with or without impaired function of excretory organs), climate, occupation, and the like.

Morrow says polymorphism constitutes a distinctive feature of drug eruptions. The erythematous varieties are in point of time the first

* *Practitioner*, 1886.

† The valuable papers of Drs. H. A. Brooke and C. Fox are both published in the *British Journal of Dermatology*, 1890.

to appear, and later those which are papular or tubercular in form, constituting nodules or bosses of very considerable size, and possibly followed by ulceration and sloughing. In illustration of this several typical cases of bromism have been exhibited before the Society. The intensity and extent of the eruption are not always commensurate with the quantity administered, some persons developing maximum effects from minimum doses. Sufficient similarity of effects or uniformity are, however, met with to allow of rough grouping. The results of such drugs as chrysarobin, croton oil, and tar are sufficiently typical to be recognized at once in the majority of instances, but such a case as that shown here by Dr. Abraham in October, 1896, and of which an illustration is given in the third volume of the Society's Transactions, showing such exaggerated consequences of the application of tar—a most severe papillary and pustular eruption on the thigh and leg of a man aged 60 years—well illustrates the occasional development of unusual features. Again, it is well known that eruptions simulating scarlet fever and measles are invariably produced by such drugs as belladonna and antipyrin respectively (Morrow).

Dr. Radcliffe-Crocker has enumerated the various forms under the following thirteen heads, viz., Erythemata, Vesicular, Bullous, Urticarial, Pustular, Purpuric, Gangrene, Persistent Desquamation, Abscess, Furuncles, Ecthyma, Zoster, and Pigmentation, and adds three others, or those which have appearances more or less simulating Eczema, Psoriasis, and Pityriasis rubra.

It must be remembered, however, that the same drug is capable of producing at different stages of its influence very dissimilar appearances. Quinine is followed by erythema, vesicles and bullæ, eruptions of urticarial and purpuric kind, exfoliation, abscess, and even gangrene. I have seen in the person of a woman, who had large doses of quinine for a considerable period for the treatment of malarial cachexia, several sloughs on the trunk and limbs which might easily have been mistaken for syphilitic ulceration. Dr. Walter Smith, of Dublin, was one of the first observers to describe the scarlatinoid eruptions following the administration of quinine in the *Dublin Medical Journal* of 1870, and later years.

The more sensitive surfaces, such as the face, flexures of joints,

&c., are naturally more prone to the effects of local irritants than other parts, besides which, as has been pointed out, the eruption may occur quite distant from the seat of contact. The course of the eruption, which is generally variable, may cease to develop after a certain stage in spite of the persistent administration of the drug.

This I have seen in several cases of bromism.* Sometimes, however, the cutaneous manifestation continues for a considerable period after the ingestion of the drug has ceased. Occasionally a seeming predilection for cicatricial tissue has been noted in cases of eruption due to the bromides.

The majority of drug eruptions on general, etiological, and other grounds, must be included in the list of toxic erythemata.

Formerly but a limited number of medicinal agents were recognized as causing cutaneous lesions (*e.g.*, roseola and urticaria after the ingestion of a few drugs, of which copaiba was probably the most common), but of late years the list of drugs capable of producing eruptions of the skin through the vaso-motor nerves has been largely added to—*e.g.*, particularly in those individuals prone to eczematous manifestations, whose cutaneous proclivities may be transmitted through successive generations, and in persons of so-called scrofulous habit and lymphatic temperament. That a textural predisposition often exists is undeniable. A clinical distinction, however, should be drawn even in eruptions from the external application of drugs, writes Morrow, "between those which are constant and regular, and those which are variable and irregular; the former depending mostly upon the drug itself, the latter upon the predisposition of the cutaneous tissues."

The eruptions following the use of iodides may be mentioned as being strangely variable, sometimes acneiform only, sometimes bullous and pustular, sometimes tubercular, and followed by the formation of subcutaneous nodules. In a case cited by Dr. Sangster so unusual were the manifestations that it was impossible by appearance alone to distinguish them from dermato-syphilis. However, with the discontinuance of the drug the lesions disappeared. In

* *Vide Clin. Soc's. Trans.*, Vol. xviii., with plate, including paper by the late Dr. Carrington; also *Trans. of Pathological Soc.*, Vol. xiii., with plate, and paper by Dr. Lees.

this relation I recall a case in my own practice which is worth recording, not merely on account of the importance of accurate diagnosis, but as showing what additional risks may be inflicted upon a patient when uncertainty prevails.

A gentleman from the North of England consulted me for a dermato-syphilide. He had had previous treatment, including iodide of potassium, but the doses were small, and as he anticipated matrimony within twelve months of the date of my seeing him, he was specially anxious for a rapid cure.

The suggestion I made was that he should increase the dose, for a period, to ten grains three times a day, and if matters did not progress satisfactorily I would reconsider his case. He left London immediately afterwards. Several weeks later I casually met his brother, an old patient of mine, through whose influence, I believe, he originally came to me. He told me that the patient returned to town a few days ago feeling very unwell, and having an eruption upon his skin. He feared it was small-pox from the appearance of his face, so a doctor was sent for at once, and he confirmed the opinion. As my friend's house was at Clapham an ambulance was sent for, and the patient was immediately removed to the Stockwell Fever Hospital.

On suggesting the possibility of an iodide rash, I was allowed to visit him. The resident Medical Officer at the hospital frankly confessed some doubt about the case, but he felt it incumbent upon him to admit the patient, which he did. A closer investigation satisfied us that he was merely the subject of an acneiform eruption due to iodide of potassium, and he obtained his discharge forthwith.

Instead of keeping to the prescribed dose, the patient had trebled it upon his own responsibility, thus taking ninety grains per diem instead of thirty grains.

Besides the influence of "local idiosyncrasy" it has been contended that part of the disturbing action of certain agents expends itself upon the skin, and also that some eruptions result from irritation of certain structures, *e.g.*, the sebaceous glands through which a particular drug is eliminated in part, while others are due to changes in the blood, including disorganization of blood-corpuscles. It is also well known that both functional and structural disorders of the kidneys predispose to the production of drug eruptions by means of defective elimination. E. Parkes, W. Roberts, L. Brunton and others have published special observations in this direction. Numerous writers have been led to the conclusion that the sebaceous glands are the seat of primary structural change in eruptions due to bromism and iodism, but instances have been recorded showing that this is not constant. Dr. Thin* described the sections he made of the skin of a patient who died during the time that an extensive eruption, due to iodide of potassium, was present, and he reported

* *Royal Med. Chir. Soc's. Trans.*, November, 1878.

that "the sebaceous glands were unaffected, the main pathological condition being the blocking of the vessels at certain points, leading to rupture and the formation of varying degrees of the local lesions."

I would specially invite the members, and any visitors present, who may have had experience, to give us the result of their microscopic investigations in this direction.

Drs. S. Arloing* and Alfred Salter† have published some remarkable observations on the subject of bacterial toxin elimination by means of the sweat in health and disease, which are worthy of the careful study of dermatologists.

Lastly, some drugs act in a specific manner upon the nervous system, and localized neuritis may even result from their toxic effects, arsenical herpes probably being the commonest example. Fagge, Hutchinson and many others have written in detail upon this subject.

To recapitulate, the active principles of drugs exercise their effects in the production of cutaneous eruption, according to Fox—

1. Upon the vaso-motor or trophic nerves (central or peripheral).
2. Upon special tissues, as skin, nerve structure, etc.
3. Upon special glands or appendages irritated during the process of elimination.
4. Upon natural function by the production of excessive action.
5. Upon the blood-vessels or their contents.

So numerous are the drugs to be included in this group (now approaching 100, I believe), that it is impossible here even to enumerate them; suffice it to say that they include some of the most recent additions to the pharmacopœia.

The hope that I may elicit the experience of others more competent than myself is my only justification for undertaking, with so brief a notice, to open the discussion to-day. I must appeal to you therefore, gentlemen, to overlook my shortcomings.

Discussion.

Dr. Payne said Dr. Stowers had treated the subject generally in a very complete manner, and it would not be possible to add very much to what he had said, except by the relation of special cases or special forms of drug eruption, which would take a very long time. Still, one or two points might be referred to.

* *Lancet*, September 25th, 1897.

† *Lancet*, September 4th, 1897.

Dr. Stowers had very justly observed that the number of drugs now known to produce eruptions was very large indeed. But to a certain extent they could be reduced to groups. For instance, there was the group consisting of quinine and the various compounds of ammonia and their derivatives, the alkaloids and amides: antipyrin, phenacetin, and the rest. There was a certain similarity in the effects of these drugs—in the first place they produced erythema, and if the action were still more intense, a bullous eruption sometimes ensued; in fact, the same results and in the same order as could be produced by direct irritation of the skin. In connection with this, it was interesting to recall the fact that very similar eruptions were produced by certain substances which they did not call drugs, but poisons. For instance, the decomposing elements of food—so-called ptomaines—produced effects very similar to those of drugs. Not only so, but, he thought, similar results could be traced to sewer-gas and other forms of decomposed animal products. It was assumed by some French writers that a particular form of scarlatinal erythema was produced by poison from drains; and he (Dr. Payne) had seen one or two cases which strongly confirmed such an opinion. In all such cases, however, whether it was a drug or whether it was a product of decomposition, the question arose whether there was a personal element or idiosyncrasy in the person affected, which caused him to be affected while others were not. A drug might be administered to 100 persons, only one of whom might manifest symptoms in the form of an eruption. He had lately had the case of a gentleman with a most widely-spread eruption, partly erythematous and partly vesicular and bullous, having already lasted two months. It had been treated with arsenic, and also with mercury and iodide of potassium, which appeared to have made it distinctly worse. The history was that the eruption first came out after taking gr. x. of antipyrin. It persisted long after that, and fresh eruptions came out without reference to antipyrin; therefore, though that was the immediate determining condition, it was perhaps not the permanent cause. He was a robust man and in healthy circumstances, except that he had been living in a house in which the drains were defective. They had been taken up and much stinking material removed. It was possible that the sewer-gas was the primary cause of the trouble, the dose of antipyrin having acted as a determining factor.

As a still further development of the subject, they saw in many specific diseases eruptions of the same kind; for instance, in small-pox. It was not the regular small-pox eruption to which he referred, but a severe erythema which sometimes occurred in the first few days of the disease. He had seen the same thing in one instance following re-vaccination. A similar erythema might be observed in the early days of typhoid fever. In such cases he thought they must attribute the eruption to the bacterial toxins liberated in the body by the organisms, not to the direct effect of the organisms on the skin itself. A parallel might thus be drawn between the action of nitrogenous drugs, of the products of decomposition of nitrogenous substances, and of bacterial toxins.

Dr. Galloway said he had very little to add to what Dr. Stowers had put before them so ably in his paper. But it occurred to him that there was one point, at any rate, in reference to the morbid anatomy of drug eruptions which it was worth while drawing attention to, viz., how very seldom it was that one saw atrophy of the skin or scarring following drug eruptions which were of the erythematous type. One knew the ingenious hypothesis which had been advanced, especially in Paris,

to explain the peculiar class of erythemata which left scars, and of which Lupus erythematosus might be considered as the type. It was stated that the poisons which produced Lupus erythematosus were probably toxins absorbed from deposits of tubercular or other morbid material in parts of the body which might not easily be investigated. The distribution of Lupus erythematosus, especially the generalised varieties of it, closely resembled the distribution of many attacks of Erythema multiforme, yet in Erythema multiforme, with very rare exceptions, there was no atrophy or scarring of the skin. In reference to erythematous eruptions which arose from the absorption of toxins or bacterial products of other kinds, he thought it would be well worth having their attention more particularly drawn to observe if scarring or atrophy ever resulted. In reference to scarring following drug eruptions, they were familiar with it in the case of the pustular and granulomatous types, *e.g.*, the halogen eruptions. Dr. Payne would recollect a curious case which he (Dr. Galloway) brought before the Dermatological Society of London recently. The case was sent to Charing Cross Hospital with the possible diagnosis of Mycosis fungoides, and turned out to be nothing more than the granulomatous form of eruption which occasionally follows the undue administration of bromides. Of course, scars resulted in that case, but in reference to the atrophy of the skin following erythematous eruptions, he thought very little was yet known, but much more might be known if their attention were specially directed to the subject.

Dr. Harrison said perhaps he ought not to relate cases, but he would like to mention that of a child in the General Hospital at Bristol under one of his colleagues, who, after continual doses of chloral hydrate, developed the best imitation of a measles rash he had ever seen. The proof of it consisted in the fact that when the drug was left off the eruption soon ceased, and on re-administering the drug the rash came out in the same condition.

There was one point he did want to raise a discussion upon. He did not hear his friend Dr. Stowers mention it, but Dr. Payne did refer to it somewhat in speaking of the "bad drains" case. The point was, that where irritation had once been set up, whatever the drug might be, there was a recurrence under certain conditions where it was impossible that the drug had been given or continued. The following case which occurred to him enlightened him on that point:—

A girl, with a previously healthy skin, enviably so, was admitted to the General Hospital. She was employed at rope-works, and in the process of preserving the ropes they used some low form of paraffin. She got a very extensive and severe dermatitis on the arms, face and neck. She was admitted to the hospital because there had been a few other cases somewhat similar in people employed at the same works, and the employés had been complaining of the new substance. In a few days the rash disappeared, and one thought there was to be an end of it; but at the end of about a week it recurred on the legs, which had not been exposed, and was very severe indeed. The girl went out of hospital, but came again some weeks afterwards with a renewal of the same symptoms, though in the meantime she had left those works; and again some months afterwards there was a recurrence. She had never had any other eruption. He had seen similar events in other cases, and was now always careful to tell the patient that the condition might recur long after ceasing to use the drug. He would like to hear the experience of other members on this point.

Dr. STOPFORD TAYLOR said he wished to draw the attention of the Society to an iodide eruption which occurred in a young lady who was suffering from rheumatic endocarditis and renal congestion. Fifteen grains of iodide of potassium in three five-grain doses in one day sufficed to produce an eruption resembling small-pox.

The eruption never entirely disappeared, her death occurring a fortnight afterwards from general dropsy.

He had seen salicylic acid ointment applied to a large surface, when combined with the internal administration of fifteen-grain doses of salicylate of sodium, three times daily, produce an eruption like a chronic papular eczema. He had also seen an erythematous and purpuric eruption develop in a man who was having his bladder washed out twice daily with a boracic acid solution; also an erysipelatous inflammation after taking two tablets daily of the thyroid extract; also measly eruptions during the administration of chloral hydrate when the drug had been pushed to relieve the itching of Dermatitis herpetiformis and the convulsions of Chorea gravis.

Dr. WALDO said he had listened to Dr. Stowers's paper with very great pleasure, and had no comment to make upon it. But what Dr. Payne referred to reminded him (Dr. Waldo) of cases he occasionally saw where an ordinary soap-and-water enema was administered to a patient, and an erythematous eruption followed the procedure. He had heard it discussed in hospital as to whether the soap was the cause, or whether the water was responsible for it. On the last patient he had who was affected in that way he tried the result of leaving off the soap, and found the eruption still supervened in just the same way.

Dr. WALSH said, with reference to the point raised by Dr. Payne, he had himself elsewhere expressed the same opinion, namely, that the enema rash was probably due to the absorption of a toxin. Similarly, he ascribed the early anomalous rashes that sometimes occurred during the acute specific fevers to toxins. It occurred to him that the early erythematous secondary rash in syphilis might be due to toxin absorption, while the later and more severe rashes might be caused by the actual local action of the organism.

Another point which struck one forcibly was the minute quantity of the drug which would bring about such results. In his own case he knew that if he took and continued ♏. v. of the liquor arsenicalis, to-morrow morning he would have a minute papular and irritating rash on the backs of the wrists. Thus $\frac{1}{500}$ grain of arsenic sufficed for that effect, and he did not gather from Dr. Stowers's paper any explanation of such action. Probably in his own case it was due to a number of internal and external influences working together. His own theory was that most of those drugs acted as direct epithelial irritants, and the rash was the result of an attempt at excretion from the body. In the case of mercury, iodine, bromide, and arsenic rashes, they found those substances respectively in the matter excreted by the skin; they also knew from Arloing that sweat was probably toxic, and that tuberculin was found in the sweat of phthisical patients. Possibly it had occurred to Dr. Stowers, in discussing the subject, that sweat should be considered as part of the action of drugs upon the skin. The theory of irritation of excretory epithelium, advanced by himself in 1880, seemed to be as nearly true as ever in the light of recent researches, and he thought there was no satisfactory alternative theory. He applied the excretory theory not only to drugs, but to bacteria and their products, and to specific morbid substances such as the gouty and the rheumatic poisons.

Mr. PERNET wished to point out, with regard to what Dr. Walsh had said, that Trousseau, a good many years ago, in his *Leçon sur les Exanthèmes sudoraux*,* drew attention to the "excretory irritation" of sweat, not only in drug eruptions, but also in the course of various diseases.† Sydenham,‡ Müller,§ and others have also insisted on the point.

The PRESIDENT (Dr. H. R. Crocker) said he had been a little surprised at the small stress which had been laid upon the one practical point which concerned them all as medical men, viz., the diagnosis of drug eruptions. The chief interest very frequently was expressed in the question, "What produced this eruption?" As a matter of fact, with the exception of the bromide and iodide of potassium eruptions, they could not definitely say such-and-such an eruption was due to such-and-such a drug. Dr. Stopford Taylor would remember that they had to diagnose an iodide eruption in spite of the evidence that the patient had taken no iodide of potassium. However, they stuck to their guns, and then Dr. Stopford Taylor elicited the admission from the patient that he had been taking Clarke's blood mixture for a time, but had forgotten the fact. It became a matter of very considerable practical interest that they should be able to do that. But with the majority of eruptions they could not say it was this or that drug which produced it. The great bulk of the eruptions produced by various drugs were really of the erythematous class, and several speakers had pointed out that drugs were not by any means the only toxins which would excite erythematous eruptions. Dr. Payne had alluded to sewer-gas poisoning, and he (Dr. Crocker) had seen cases of that kind in which, as far as the eruption was concerned, it would be impossible to distinguish between scarlatina and the scarlatiniform eruption. In one case in which he gave a very confident opinion that it was a toxin, it was clearly traced to drains.

* *Clinique Médicale de l'Hôtel-Dieu de Paris*, Deuxième Edition. Paris, 1865. Tome Premier, p. 199 *et seq.*

† "Un malade prend de l'opium de manière à produire la stupéfaction. On sait que dans ces conditions, l'opium provoque habituellement des sueurs assez abundantes, que c'est de tous les sudorifiques le plus puissant et le plus actif. Lorsque, entraîné par le torrent de la circulation, il vient se présenter aux divers émonctoires, et particulièrement à l'émonctoire cutané, plus spécialement chargé de l'éliminer, il y détermine une irritation, et l'on observe alors des exanthèmes," etc. . . . Trousseau, *loc. cit.*, p. 204. Further on he says; "Ces exanthèmes sudoraux s'observent dans le cours d'un grand nombre de maladies: c'est qu'alors, en effet, la sueur, altérée dans sa composition, prend des qualités irritantes, sous l'influence desquelles surviennent les affections dont nous parlons, soit que la quantité de la transpiration s'exagère, soit qu'elle reste la même."—Trousseau, *loc. cit.*, p. 206. See also many other passages, *loc. cit.*, pp. 202, 203, 204, 205, 207, 208, 209.

‡ ". . . and therefore I do nothing to hinder the Despumation of the Blood, and the ejecting of the peccant Matter through the pores of the skin. . . . "The Whole works of that Excellent Practical Physician Dr. Thomas Sydenham. From the Latin by John Pechey, M.D., etc., London, 1697, p. 201, Chap. II., Of the Scarlet Fever. *See* also pages 66 to 76, *op. cit.*

§ ". . . and in the exanthematous diseases, in which the morbid matter is excreted by the skin. . . ." "Physiology," translated by Dr. Bayley, London, 1840, Vol. I., p. 630.

With regard to erythema following enemata of soap-and-water, the solvent action of the water dissolved the toxin in the intestine, and the absorption of this produced the rash. But in ordinary cases they could not say what drug produced the eruption unless they had some collateral evidence. With many of those erythematous eruptions it was only their persistence or their frequent recurrence which caused them to investigate all outside conditions. He remembered a case sent for diagnosis with persistently recurrent erythema limited to the backs of the hands. Sometime afterwards it was clearly traced to antipyrin, which the patient took from one of his son's prescriptions for headache. It might be that the drug had a direct action on the vaso-motor system, or in some instances the action might be quite a reflex one. So closely did the eruption follow the ingestion of the drug in some cases, that it was difficult to believe that the action could be anything but indirect. In other cases they might get evidence that it had a direct action on the vaso-motor system.

One striking fact, which he did not remember whether Dr. Stowers alluded to, was that very few drugs produced a general eruption when administered otherwise than by the mouth. The only drugs with which they could produce general eruptions, when they were administered by the skin, were iodoform, belladonna, and mercury. General erythematous eruptions sometimes followed local applications of belladonna, and mercurial inunctions were occasionally accompanied by a general exfoliative dermatitis, like Pityriasis rubra; but all the other drugs when administered hypodermically did not produce an eruption. That was a striking fact, and might be suggestive that there was nothing very specific about it. In some cases it might be simply the result of reflex irritation.

Dr. Stowers, in reply, said that Dr. Payne's experience suggested new points to him, as he had not previously associated erythematous eruptions with the influence of sewer-gas, &c., but would bear them in mind as a guide to future observation. He fully concurred with the remarks of Dr. Galloway and Dr. Stopford Taylor.

It was difficult to find a satisfactory explanation of the point raised by Dr. Harrison. It was not improbable, however, that the recrudescence depended upon a process similar to that which led to recurrent irritation after the attack of some external parasites.

With regard to the eruptions produced by chloral hydrate, in the cases seen by Dr. Stowers, they were papular in form on an erythematous base, and not exactly as Dr. Harrison had described them.

In reference to Dr. Walsh's remarks, he regretted that shortness of time had obliged him to omit several paragraphs in his paper, including one which related to the subject in question.

With regard to the Chairman's observations, he thought that a diagnosis could often only be satisfactorily made by a process of exclusion, added to the result of previous observation and experience. Had he had more time at his disposal much could have been said upon this part of the subject.

Concerning the statements of patients themselves, they were often misleading, and occasionally positively fallacious. Dr. Stowers briefly narrated the last instance of the kind which had come to his notice that day. He concluded by inviting the members and visitors present to examine a coloured drawing which he handed

round, showing the eruption which occurred over the entire body and extremities of a male patient who was admitted into hospital in 1894, after swallowing a quantity of oxalic acid with suicidal intent. The man was dangerously ill for several weeks, but eventually recovered, the severe vomiting immediately produced by the drug having saved his life.

The eruption was papulo-erythematous in form, and very acute.

Numerous other drawings to illustrate the subject were exhibited.

A hearty vote of thanks to Dr. Stowers for his address was carried by acclamation on the motion of the President, and suitably acknowledged.

June 29th, 1898.

An ordinary meeting of this Society was held at 20, Hanover Square, London, on Wednesday, June 29th, 1898, Dr. H. Radcliffe-Crocker, President, in the Chair.

Clinical Cases.

Dr. Savill sent a private patient, previously shown to the Society,* as a case of vesiculo-necrotic eruption of (?) angio-neurotic origin. The following notes on the case were read :—

"The patient has had a relapse under somewhat interesting conditions. You may remember that she was quite well when last before the Society, cured by special treatment away from home. Her home life is surrounded by a good deal of worry, and she is extremely anxious about an invalid boy, over whom she frets when at home nearly all day long. This is the cause, in my opinion and that of her doctor, of the relapse.

"You may take it as quite certain that this eruption is not due to artificial means, as first suggested itself to our minds.

"(1.) Dr. Bolton Tomson took the case in hand himself, and did the dressings twice a day in such a manner that they could not be disturbed without it being detected, and he watched the spots evolved in parts in healthy places beneath such dressings.

"(2.) I myself adopted the same measures when she was under my care in London, and had the arm dressed with simple vaseline.

"(3.) It may be noted in passing that the eruption has always been of precisely the same character over the long period of three years, and that the eruption is quite unlike any hitherto described traumatic eruptions.

"The main features of the case are that it started three years ago, and has successively involved the left arm, the right arm, left leg, and left arm again. Once or twice the face has been attacked. The patient is a highly nervous one, and has presented hysterical faints and other functional nerve symptoms. Her circulation is very feeble; the eruption is always preceded by pain for one or two clear days, and altogether we may regard this last relapse as again confirming the nerve origin of the condition."

In a further communication Dr. Savill wrote :—

"Since writing you, the patient has had the eruption on the face. Here it assumed, as on the former occasion in that position, a hæmorrhagic nature—like

* *Brit. Jour. Dermatology*, June, 1898, p. 200 *et seq.*; also *Trans. Derm. Soc. of G. B. and I.*, Vol. IV., 1898, p. 50, Plate V.

the little black specks which I described last time; and as it looks, under the circumstances, exactly like the stain of nitrate of silver, Dr. Bolton Tomson had some of the scales we picked off together analysed for silver—to make assurance doubly sure, as we cannot cover up the face as we did the arm. Enclosed is report of the analysis."

"*Report.*—Using the most delicate processes known to us, we have failed to detect any trace of silver in these patches. The skin was subjected to prolonged extraction with cyanide of potassium, and in the solution an attempt was made to obtain a deposit of silver by electrolysis. The results were wholly negative, though control-experiments showed the extreme delicacy of the method."

Dr. Savill concludes:—

"We must clearly look for some other cause than trauma in this strange case."

The PRESIDENT said he confessed he could not offer a solution of the case. An irritant would account for it, but he did not know of any natural process or disease into which it could be pigeon-holed. Of course, "angio-neurotic origin" was one of those theories which they liked as a refuge, but it did not explain very much.

Dr. EDDOWES said if he had known the case was coming up, he would have brought a photo of a patient of his who suffered from the same condition, he thought. She came from Brighton a few months ago, and told him that her rash appeared about once a month or six weeks at the back of her hands and arms. Some of the lesions were somewhat irregular, and just raised above the level of the surrounding skin. A little fluid was underneath; the horny layer in some parts, and some of the lesions, were hæmorrhagic. The arm generally pained her for several hours, and then she knew the rash was coming. Curiously enough, if she caught cold and had fits of sneezing the appearance of the rash was the signal for the disappearance of the symptoms of catarrh. Her age was 50, and she had enjoyed a very healthy life. There was no history of syphilis or other illness to account for the eruption.

The only suggestion as to causation which she had to offer was that some days before the first outbreak she did some cooking, with her sleeves rolled up, in front of a large fire on a cold day, and that she exhausted herself with work which she had not been accustomed to, in order to prepare for some company. The rash seemed to commence with symptoms of rheumatism. Dr. Eddowes considered that Erythema bullosum was a good name for the condition, although it must not be thought by that he confounded it with Erythema multiforme, of which he had recently spoken before this Society.

Mr. PERNET said that, having seen Dr. Savill's case when it was first shown, and seeing it now in an acute condition, he could only say that he still felt convinced it was a case of malingering.

The PRESIDENT showed (1) a case of *large-spored Ringworm.* It was interesting on account of its very close resemblance to Alopecia areata, yet there was a distinct difference. It corresponded to what Sabouraud called Peladoid ringworm in the bareness of the patches; the difference consisted in the irregularity of the outline of the patches, and the want of sharp definition of the bald edge. After a

great deal of searching, they found one or two of what might be ringworm stumps, but Mr. Pernet was unable to find the fungus at first, but after soaking the hair somewhat longer and examining again Mr. Pernet did find it—a large-spored Ectothrix. The case showed that even without microscopical examination one could, in a case like this, suspect it to be ringworm rather than ordinary Alopecia areata.

(2) A case of *Lupus verrucosus*. It was very symmetrical on the point of both elbows and also on the knees, and although the girl was young she had had it twelve years. The theory was that some focus of tubercle bacilli, like a softening gland, had discharged bacilli into the circulation, which had sown them broadcast. He had seen as many as fifty lesions in one patient.

Dr. EDDOWES showed a girl with a large number of more or less symmetrical white patches on the back, many of which had existed for over twelve months. There was still a tendency to increase in number. He had called it Leucodermia; but he was prepared to substitute another name—viz., morphœa, although there were some points which suggested leucodermia to his mind. He looked upon leucodermia as indicating a condition rather than a definite disease. At the margins of the white patches there was a slight redness; and the skin on the back, generally between the white patches, was somewhat darker than on the rest of the body, as though the pigment belonging to the white patches were distributed elsewhere; a sign so characteristic of leucodermia. There were no symptoms worth mentioning. He was using a mild unguentum sulphuris, which had apparently, and decidedly in the girl's mother's opinion, cured the most recently developed spots. There was very little sign of infiltration in any of the patches.

The PRESIDENT said he regarded the case as one of Morphœa. Changes in the texture of the skin and atrophic conditions were not very rare in morphœa, while in leucodermia there was no lesion whatever except the pigment disturbance. It was a very interesting case; in fact all sclerodermic cases were interesting, and worth bringing before the Society, as they each had their special features.

Dr. WALSH showed a girl, and read the following notes:—

M. S., female, single, domestic servant, æt. 18. Sent by Mr. Sydney Stephenson, in May, 1898. Complaining of a disfiguring condition of right eyeball and lids, that had existed since infancy, but had not got worse. Right eye: Externally

there is apparent lengthening of eyebrow, and the eyeball is prominent. The palpebral fissure measures 38 mm., as against 26 mm. in the left eye. The lids are swollen and unthickened, but can be distinctly pitted on moderately firm pressure. The intermarginal space is twice as broad as that of the other eye. The pupil is small; the eyeball smaller than the sound eye; there is an external strabismus of 25°. The ocular conjunctiva shows a nævoid and vesicular condition, as described later.

L. E.—V = $\frac{6}{6}$.

R. E.—V = $\frac{9}{9}$ Jæger.

Can make out number of fingers held up against strong light at 1 mètre.

R. E.—Disc, ill-defined. Retinal vessels, large and rather tortuous. Vessels tortuous and swollen. Both eyes show dotted opacities in lens, less marked in left. Several strands of persistent pupillary membrane present.

R. E.—Nævoid condition. There is an enlarged caruncle and enlarged semilunar fold, which has a pale œdematous look. The fold is lost above and below in thickened conjunctiva; and externally is continuous with a translucent and vascular growth on the ocular conjunctiva. This growth consists of a number of jelly-like elevations—arranged roughly in the shape of a ring round the cornea, leaving a clear space of about $\frac{1}{8}$ of an inch round the cornea, except at its upper segment, where they touch the margin. These yellowish translucent elevations have numerous punctate hæmorrhagic injections and fine blood-vessels. In places the jelly-like bodies are about $\frac{1}{8}$ inch thick, and are pouch-like. The patient states that the eyelid gets black at times. There used to be a lump sometimes at the inner angle of the orbit.

The capillaries on cheeks are dilated.

The interest of this condition is its exact resemblance to Hutchinson's *Lupus lymphaticus*. The jelly-like pouches on the eyeball are clearly varicose lymphatics. It seems possible from the history, and from the dilated surface capillaries and congested retinal vessels, that the eyelids and orbit may be affected with a mixed vascular and lymphatic nævus. In that case the different external appearance of what we assume to be a common underlying pathological condition is interesting. The elephantiasis of eyelid and the nævus lymphaticus of eyeball, if this view of common origin be accepted, are possibly two differing external expressions of some congenital local affection of angio-lymphatic type. The present lesion is congenital, non-infective, chronic, associated with a congenital nævoid condition. Hutchinson figures a patch at back of tongue in a young girl, and remarks that the aspect of the mucous membrane exactly resembles that of skin (Plate LXXXVI. "Smaller Clinical Atlas").* This, however, is not his lupus lymphaticus, because it is non-infective, and, so far as one can learn, not liable to attacks of erysipelatoid swelling.

The PRESIDENT said he agreed that the case came into the same category as those which Mr. Hutchinson called Lupus lymphaticus, but which had been better called "lymphangiectodes," or *Lymphangioma circumscriptum*. He had seen it on mucous membranes, but not on that of the eye. It was evidently a congenital defect. Whether it was really connected with the lymphatics or was primarily vascular, in which the blood became absorbed, was open to doubt. Most of those

* Comp. Jonathan Hutchinson's "Smaller Clinical Atlas," Plates XV., XVI., LXXXVI., LXXVIII.

who had made a histological examination considered it to be of lymphatic origin. Judging by results on the skin, excision was not very successful.

Dr. EDDOWES suggested that the word "lupus" was inappropriate. He looked upon it as a congenital lymphatic nævus.

Dr. F. RUFENACHT WALTERS read a paper on

AN ANOMALOUS RASH IN TWO CHILDREN.

I must apologize for bringing some incompletely recorded cases before the Society. I thought, however, that the interest attaching to a living specimen outweighed the advantage of a more perfect record, which could only be supplied later if at all.

The cases may almost be called a personal experience, as they concern my two little girls, aged respectively three and six years, and to a less extent some adult members of my household, and are, I believe, connected with skin disease in two dogs, of which I have brought one to show to the Society.

The rash has repeatedly attacked one or other of the children during the last three years, completely disappearing under treatment in the intervals. It consists of scattered papules, at first scarcely noticeable, but causing much irritation, and soon becoming complicated with urticaria and scratch marks. Many of the papules have become vesicular in the younger child, but none have been pustular, nor have they given rise to weeping, the formation of crusts, or enlargement of glands. On many occasions I have seen white lines leading up to the papules, resembling those of scabies; but I have not made any thorough attempt to find an acarus, as I was much occupied with other work, and found the disease fairly easily curable by simple measures.

The rash usually came on in bed. It attacked more especially the sides of the fingers, border of hand, flexor aspect of forearm, and wrist, corresponding parts of the lower limbs, and flexor aspects of the trunk, with occasionally a few spots in the younger child on the face and neck. The back and extensor aspects have been unaffected, excepting sometimes by the urticaria. The spots have almost always been isolated; but occasionally a group has appeared round an earlier spot. If promptly treated with sulphur ointment, the irritation has speedily disappeared, the papules remaining for another four or five days and gradually subsiding. When treatment has not been vigorous, fresh spots have very soon appeared in the neighbourhood.

The elder child was first affected; she became less subject to the attacks as she grew older, but has recently had a severe attack on the hands. A spot appeared causing some irritation; it was not promptly treated according to directions, and a regular crop of spots soon appeared between the fingers, and along the borders of the hand, and in the creases of the wrists. Sulphur ointment was vigorously rubbed in, and there is now only a little dry eczematous rash remaining. During the last six months the baby has been the chief sufferer. In her the proportion of vesicles has been greater than in her sister; and I found that much better results were obtained if these were pricked with a needle before the ointment was rubbed in. For the subsequent irritation, creolin lotion has been useful; for the

urticaria, nothing succeeded better than a small dose of bromide and dabbing with carron oil. The elder child paid a visit to some cousins some time ago, and one of these—a little girl aged three—caught the disease from her. We were under the impression at the time that our own child had got rid of all active disease. Those in attendance on our children—the nurse, my wife, and myself—have had occasional spots, mainly on the sides of the fingers, and sometimes irritation there, without any visible spot. Neither have lasted long.

Etiology.—I at first regarded the disease as ordinary scabies, although I was much puzzled to account for it. When the attacks began to recur, and I could not prevent them by disinfection, or destruction of clothes and toys, I consulted Dr. Abraham, who gave me some valuable advice as to treatment, but did not satisfy me as to the cause of the rash. The disease was subsiding when he saw the child, and he found no clear evidence of scabies, and doubted its being of this nature. I had myself been troubled with sebaceous eczema; but the almost complete absence of scalp affection and of scaly patches in the children makes it unlikely that their complaint was the same. Papular eczema is more common on extensor surfaces, and its spots are usually grouped, which was not the case with the children. Moreover, the distinctly contagious nature is against papular eczema.

I could find no constant association with free perspiration, the use of particular kinds of soap, irritation of clothing, special articles of food, constipation or dyspepsia. Some of the attacks happened when the children were perfectly well in every respect.

One probable cause, however, remained. I have two Irish terriers who have been for a long time under treatment for what Mr. Woof, the veterinary surgeon at Croydon, informs me is red mange, and in which he states that he identified the parasite. I have not confirmed this diagnosis, but have little doubt it is correct. The disease began in them as red and very irritable patches, which became lumpy and pigmented, and sometimes raw from biting, and led to shedding of the coat in patches. On two occasions Mr. Woof had them for several weeks under treatment with mercurial ointment, and they came back apparently cured; but the disease returned directly the treatment was interrupted. I have myself found that creolin baths are useful in checking the disease; but they must be frequently repeated—once or twice a day—to be efficacious.

Red mange is attributed to the presence of a species of Demodex, closely related to, or possibly identical with, the human Demodex folliculorum. The latter is, I believe, larger; but Gruby found that if inoculated into a dog, it produced apparently typical red mange. Other mites—species of sarcoptes—are also described as parasitic on animals, and occasionally transferred to man; but the disturbance caused by their presence is said to disappear spontaneously in a few weeks. In the absence of personal microscopical evidence, I am unable to say which was present in my dogs; but the cases related tend to show that red mange in the dog may at times give rise to very troublesome eruptions in children. It is also interesting to notice that the younger the age the greater the disturbance.

In the discussion Dr. WALSH said, when he was a student at Edinburgh, some students' dogs had an irritating rash, which was communicated to at least six men, who complained of intense irritation. That yielded very quickly to treatment with liquor carbonis detergens. Again, when he was officiating as *locum tenens*, a theatrical manager consulted him for a slight but intensely irritating

rash, with a few extremely small and sparsely scattered papules. He had slept with a mastiff puppy, and on seeing the dog, he (Dr. Walsh) found on its belly a few scattered pustules. He took some of the hairs, but could not find any fungus. It seemed to him it might be a streptococcal inoculation. Again, while staying in the country a year or two back, a spaniel had an intense affection, which was not communicated to man. The spaniel got it through sleeping in a kennel which had been occupied by another dog, which was so severely affected that it died. There were some distinctly solid hyperplastic warty growths on the dog, and a good deal of alopecia. He applied creolin and antiseptics vigorously and the condition improved, and eventually the dog had a beautiful skin. But he had seen the dog since, and it was scratching again. He could get some of its hairs for any member who might wish to examine them. Dr. Walters' communication was extremely interesting, but the acarus not having been found, they could hardly deal with it scientifically. These dog rashes seem to be extremely infectious, very irritating, and appeared to consist of multiple lesions.

The PRESIDENT said he could record a personal experience which he thought was somewhat similar to Dr. Walters'. A short time ago he became possessed of a Japanese puppy spaniel. It developed a very irritating rash, which he thought had commenced when it was purchased. He applied the name "canine scabies" to the condition. The dog was taken away to Brighton, where a veterinary surgeon said it was a species of distemper. At any rate it was a species of distemper which communicated itself to two human beings, and when he saw them they undoubtedly had a form of scabies. The dog was taken to Mr. Sewell, in London, who said that the condition was undoubtedly canine scabies of very marked form. Several attempts to find the acarus were not successful. In animals scabies did not seem to present the same burrows as in the human subject, and it was very difficult to find the parasite. The little dog was treated with some paraffin application, but veterinary surgeons did not reveal their secrets. It was very much better, but not absolutely cured. Previously it had had naphthol until distemper was diagnosed. Naphthol ointment speedily cured the human subject. The disease was communicated to a smooth-haired dog, where, of course, its characters were very much more obvious. He had very little doubt that the case was of the same character as Dr. Walters'. Judging by the veterinary descriptions, the eruptions due to the Demodex folliculorum were of a more suppurative character than those due to the acarus scabiei.

Dr. WALTERS, in reply, said he noticed in his dog in the early stage small lumps like those mentioned by Dr. Walsh. It was also interesting to notice that in the human subject, the younger the patient the more marked was the disturbance.

Wednesday, October 26th, 1898.

An ordinary meeting of the Society was held on Wednesday, October 26th, 1898, Dr. H. RADCLIFFE-CROCKER, President, in the chair.

CLINICAL CASES.

Dr. EDDOWES showed (1) a case of *Alopecia areata* in a man aged about 30, a groom. He first saw the case upon the previous evening, when he was struck by the contrast between the patient's red ears and face and the white skin of the bald scalp. The condition had been present eight months, and the only treatment adopted for it had been sulphur ointment. The patient stated he had been very ill with Hodgkin's disease, in a Cheltenham hospital, three years ago. He had had enormously distended glands in his neck, and there was still some trace of glandular enlargement in the axilla. In other respects the patient seemed in good health.

The PRESIDENT said that in some cases of alopecia, and undoubtedly in those of neurotic origin, there was marked flushing over the malar prominence, but as this patient's occupation exposed him to the weather, he was inclined to think the flushing in his case had no relation to the alopecia.

(2) A boy with *Alopecia areata*, whose bald patches were very anæmic-looking. The case was one of the most obstinate of its kind that he had encountered. He had thought the scalp where the hair still existed looked unusually dark, and he had suspected that there was increased pigmentation. Even now he thought it probable that there was more than the usual amount of pigment there. He had inquired whether the boy had any spots elsewhere, and had found to his astonishment two patches, one on the inner aspect of each knee, just over the head of the tibia, each spot about the size of a shilling, with a white centre and a dark border. It would be recognised that these were absolutely symmetrical patches of leucodermia. The difficulty he had experienced in getting the hair to grow somewhat confirmed the view expressed by Dr. Thibierge, of Paris, and mentioned in Dr. Crocker's book, that these cases, when combined

with leucodermia (and of which cases the leucodermia appeared to be a part), were extremely difficult to treat.

The PRESIDENT said with regard to the connection between leucodermia and Alopecia areata, he thought there was no doubt about there being such a connection; there were too many cases in which they were associated to justify their regarding the connection as a coincidence. He did not know that he could quite confirm Dr. Thibierge's statement, that where the two diseases co-existed the alopecia was necessarily obstinate. He had in mind the case of a child who had a severe fright due to waking up and finding a cat sitting upon her. She became totally bald, and also had leucodermia; in fact, a picture of her hands was reproduced in his "Atlas" as an example of that disease. In these sudden neurotic cases of baldness the prognosis was always unfavourable. He regarded Hodgkin's disease as a mere coincidence in the case.

(3) A man aged 58, who came to the hospital a few weeks previously with a very red face and almost confluent nodules over face and scalp. He had had the condition nine weeks. There were a few typical lesions left, and where blood-crusts were now visible there had been the centres of nodules which were dying away. The man's hands showed gout in an extreme degree. Some of the patches looked as if they might have been little points of psoriasis, but, putting all the facts together, Dr. Eddowes was inclined to the idea that the patient had been taking iodide. Dr. Eddowes had treated him simply for his gout, without bromide or iodide, and he had improved very rapidly, there being not nearly so much congestion and swelling of the nodules as formerly. The man had been using "gout pills," and had also been taking some tabloids which were supposed to contain lithia. There was a similar eruption, but a little darker in colour, on the feet and legs.

Dr. FOSTER MACGEAGH (Visitor) said that it occurred to him that some of the patches on the leg and foot were more or less suggestive of psoriasis in a gouty patient.

Mr. HARE asked whether there was any history or trace of specific affection in the case.

Dr. ARTHUR HALL (Sheffield) asked whether Dr. Eddowes had any direct evidence that the man had been taking iodide of potassium, and whether he knew what was the precise composition of the supposed lithia lozenges. It would also be interesting to learn whether the man had any nephritis.

The PRESIDENT said that on looking at the man's legs he was inclined to regard the case as one of psoriasis. One did sometimes see that alcohol played a very prominent part, and he thought it highly probable that there was some kidney trouble in the case. On looking at the head alone he was very much puzzled by the nodular character, which was much greater there than on the limbs. It was,

he thought, really a case of alcoholic psoriasis. The Society was much indebted to Dr. Eddowes for bringing the case forward. With regard to having direct evidence, one often had to diagnose iodide of potassium eruptions without any evidence whatever, and many of the quack nostrums of the day contained iodide of potassium, such, for example, as Clark's blood mixture. He remembered tracing a case of eruption to that. He diagnosed iodide eruption, although the patient denied having taken any medicine of any kind, and it was only after pressing it home very much that the fact was ascertained. It was not very likely that iodide of potassium would be put into pills.

Dr. EDDOWES, in reply, said there was no history of syphilis about the patient. The possibility had at once occurred to him. With regard to the diagnosis, he had not taken up any very definite position, having announced the case as "Query, iodide rash." He had thought of syphilis and psoriasis, though the distribution was not characteristic of the latter. One of the man's pills was dissolved in a test-tube, and some acetate of lead added, producing a yellow deposit, which he supposed was iodide of lead. He had not tested the tabloids. He would be very willing to watch the patient and bring him up again later on, and would have his urine examined.

Dr. SAVILL showed a case of *Sclerodermia** of the extremities, the patient being a woman, aged 41, who had been under his care about a year. His diagnosis was sclerodermia, but it was open to discussion whether all the symptoms of the case were explicable by that disease. The patch on the side was, without any doubt, morphœa (sclerodermia), but the affection of the limbs was open to discussion. She first noticed the patch on the side 3½ years ago, and some months after that she had sloughing of the extremity of the second toe on the right foot. At the same time she had shooting and pricking pains in the feet and arms, and then the skin of those parts was harsh and thickened, and at times red, sweating, and swollen; generally, however, the skin was harsh, smooth, and very thick. The condition prevented her closing the hand or bending the ankle, and she was crippled in consequence. She had also some swelling of the small joints of the fingers, and a good deal of pain in all four extremities. Later on, there was slight muscular rigidity, and wasting of both forearms and both legs. He used at first salicylate of soda and some other remedies, but she had done better under thyroid extract than anything else, having improved remarkably during the last three months. She had been taking thyroid six months.

In favour of the affection of the extremities being ordinary sclerodermia there was the fact that she had an undoubted patch of the

* Previously exhibited. *Vide Trans.*, Vol. IV., p. 19.—ED.

disease on the side of the thorax and abdomen, and, too, there was the appearance of the skin of the extremities when she first came under observation. Another view of the case was that the whole might be due to some spinal lesion, which would be supported by the muscular atrophy, the rigidity, and the symmetrical nature of the lesions. He gave salicylate of soda because there was pain and swelling of the small joints of the extremities, which some people might have thought resembled rheumatism. A third view might be that the lesion of the side was a separate disease from that in the extremities. The thyroid had not benefited that lesion to the same extent as those in the extremities.

The PRESIDENT said they had not had the advantage of watching the case, as Dr. Savill had had. The recovery from any sclerodermia in the extremities seemed to be now complete. It was extremely rare to have cases of sclerodermia of the morphœa type associated with deeper-seated sclerodermia; still, such cases did occur. A case was attending University College Hospital at the present time, in which there was an atrophic morphœic condition in very much the same position (the patient was a boy), while the deltoid and triceps were extremely hard, though much of that hardness had now disappeared. He would like to hear from Dr. Savill whether he had done anything besides administering the thyroid.

Dr. SAVILL, in reply, said he could not now remember all the other remedies he had used internally, but she had had a liniment which was used for some time, though without benefit. He believed she also had the descending constant current to the arms. Iodide had been given internally, 10 grains thrice daily, from November 1897 to March 1898, with occasional intermissions; but the main remedy, and apparently the most efficient, was thyroid.

The PRESIDENT showed (1) a case of *tuberculated Leprosy*. The patient was a Hindoo, who was brought up as a barrister. The disease was of nine years' duration, having commenced soon after his arrival in this country. It was a very marked case, and the patient was blind in consequence of irido-cyclitis and keratitis. He was not now (since treatment) so apathetic as formerly. The leprosy was chiefly in the extremities and the face. On the hands the skin was soft and satin-like, finely wrinkled like the senile skin, and elasticity was absent. In some parts there was a superficial dermatitis.

In cases of tuberculated leprosy, there was often immense thickening of the skin, and sometimes the anæsthesia was due to infiltration of the peripheral nerves by the exudation, and then the

distribution was not so definite as when a trunk nerve was involved, nor was the anæsthesia so complete. It was asserted by some that nodules never occurred in the scalp; that was not correct, as they did sometimes. The colour of the patient's skin was not much darker than that of Europeans who had contracted leprosy; they generally had a deeply-bronzed skin, and he showed such a case in the summer.

The PRESIDENT also showed (2) a case of *Urticaria pigmentosa.* There were three types of urticaria pigmentosa:—(1), in which there were abundant nodules like those of Xanthoma; (2), the type in which the wheals subsided and only left pigmentation, and (3) an intermediate condition where there was a certain amount of pigmentation and of permanent nodulations, but not xanthoma-like in type as one finds in more typical cases. In nearly all these cases there was a certain amount of factitious urticaria, and when a scratch was made over the tubercles they swelled up. The great bulk of such cases commenced in early infancy, generally during the first weeks of life, and persisted for many years. But in this boy the condition did not begin until he was between 6 and 7 years of age. One or two cases had been recorded, even in adults. One large xanthoma-like nodule in this patient was excised, and he would bring a microscopic specimen on a future occasion. The nodules were not now so prominent as before treatment. Itching was a very variable feature in such cases. Sometimes there was scarcely any at all.

Wednesday, November 23rd, 1898.

A meeting of the Society was held on Wednesday, November 23rd, 1898, Dr. H. RADCLIFFE-CROCKER in the Chair.

CLINICAL CASES.

Dr. EDDOWES showed (1) a woman who came under his care a month previously with a diffuse *Erythema of the face*, which had existed twelve months, and very marked œdema under both lower eyelids; the whole face being of a deep red colour. On the shoulders and round the neck she had a very sharply-marked area of redness continuous with that of the face, in the form of a cape, bearing a somewhat clear shoulder-strap of quite normal-looking skin. She had also lines running down both arms symmetrically, in the form of a broad band of red skin about two or three inches wide. Clinically, one would say, the condition of the face ought to be described as a persistent erythema with œdema. No nodules could be seen in the face, but towards the hands there was a tendency to a condition like Lichen planus. He had shown the case at Mr. Hutchinson's clinic, when that authority described it as one of inflamed Lichen planus. He (Dr. Eddowes) would rather describe it as persistent erythema, tending to lichenification at the extremities. Apart from what he imagined to be the nerve distribution of these lesions, a very striking appearance presented itself, viz., some very sharply-defined lines here and there, especially on the flexor aspect of the forearms. On feeling these lines he found the flexor tendons lay immediately underneath, and, no doubt, when the patient rubbed the part the infiltration of the lichen was aggravated by the tendon beneath acting as a rubbing post, the resistance being similar to that produced on the finger by a harp-string. Her condition was now much better than a few days ago. At one time she had a tendency to exfoliation of the epidermis on the neck, leaving a sticky surface beneath, when there was a feeling as if the surface had been burned. He therefore applied carron oil; and the treatment had been very beneficial. There was not any history

of syphilis, and the alcoholic element in the case was probably slight. He invited hints as to treatment. Internally she had had quinine and citrates.

Dr. PAYNE thought it a very remarkable case, and it reminded him of some cases which were shown at Edinburgh by Dr. Jamieson, which the latter thought to be a peculiar form of Lichen planus; other names, however, were given to it. The disease was undoubtedly something like Lichen planus, but it was not the same in every part, and there were no characteristic patches on the wrist. He inclined to regard the disease as an aberrant form of Lichen planus, but further observations were needed.

Dr. MOUILLOT (Harrogate) said he agreed with Dr. Payne that the case was very like three shown by Dr. Jamieson at Edinburgh, which Dr. Unna claimed as examples of "Parakeratosis variegata."

The PRESIDENT said he was inclined to take the same view as Dr. Payne in many respects. The resemblance of the condition to Lichen planus was very strong in the extremities, but it was extremely unusual for Lichen planus to attack the face. Even where the Lichen planus was almost universal the face very frequently escaped. That feature would make him hesitate to accept the diagnosis of Lichen planus. He thought the colour arrangement was very like that of the cases which Unna had unhappily christened Parakeratosis variegata. In the College of Surgeons there was a wax model of a case somewhat similar by Sir Erasmus Wilson, and he called it Lichen planus. That showed how close was the resemblance to Lichen planus, for if anybody knew Lichen planus Sir Erasmus Wilson, the discoverer, did. The present case differed from Parakeratosis variegata in that it had large clear areas with dermatitis enclosing them, so that the body was a mixture of rather well-defined healthy areas surrounded by spots of disease. He hoped Dr. Eddowes would show the case again later on, so that they might note its progress.

(2) A man suffering from Lichen planus.

Dr. PAYNE showed an elderly man with a lump on his scalp, which was much more prominent when he first saw it than now. It was then so distinctly a mass that at first it seemed as if it must be a new growth; or, failing that, Mycosis fungoides. But closer inspection showed it was not a definite neoplasm, but an aggregation of papillomata or papillomatous elevations grouped together; and in many instances normal hairs could be seen growing through the mass, which would be impossible if it were a true new growth. At one time there was a good deal of suppuration, and crusts appeared over the lesions. At the present time the condition was much improved; even epidermis was forming in a few places. The patient had had it for ten years, and four years ago it was entirely cut out and removed by a surgeon, but it recurred in exactly the same

place. He had been under Dr. Payne's care for somewhat less than a year. The raspberry appearance of the disease suggested the exotic disease Frambœsia. He, however, did not think it was that disease; but it suggested the name which was used by Hebra a good many years ago—Sycosis frambœsiformis. He found that the case called by Hebra "frambœsiformis" had been called by some dermatologists Acne keloid, and by others Dermatitis sycosiformis capillitii. The only case he remembered seeing like it was one brought some years ago to the Pathological Society by Mr. Morrant Baker. That was on the nape of the neck. The mass was hard, and hairs were growing through it. It was named Acne keloid. In the present case there was no hardness, though the lesion was firm. Another factor was that it was decidedly superficial, and it could easily be moved about. He had brought for inspection the plates of Hebra's Atlas. Another suggestion which was made about such affections was that they were due to specific disease. Syphilis, for several reasons, was quite impossible in the present case. First, it had lasted ten years in much the same condition. Secondly, there was no syphilitic history. Thirdly, antisyphilitic treatment caused no improvement. He believed the condition was exceedingly like Acne keloid. With regard to treatment, excision had failed to cure it, so had treatment by destructive caustics. The only beneficial effect had been produced by simple anti-inflammatory remedies, such as coal-tar ointment.

The PRESIDENT said the disease depicted in the plate suffered, like many diseases of the skin, from too many synonyms. Kaposi had described the same affection under the name Dermatitis papillaris capillitii, which Dr. Payne did not allude to. He believed Acne keloid was a sequel of that. It seemed to be a folliculitis probably due to a micro-organism. He quite agreed that, morphologically, they did look alike, but the behaviour seemed to be different. The fact of the condition in the present patient having recurred after excision made it doubtful whether it could be quite the same disease.

Dr. EDDOWES suggested that it might be of the nature of a post-mortem wart, *i.e.*, tubercular.

Dr. PAYNE, in reply, said he was glad there was a general agreement with his diagnosis, although the President regarded Acne keloid as a later stage or sequel of the condition. With regard to the suggestion of Verruca necrogenica, he could only say that he had one of those warts himself which lasted two years, and he did not think it was at all like the condition now under discussion.

The PRESIDENT showed (1) a youth the subject of mixed *Sclerodermia*.

When Dr. Savill brought forward a case of mixed sclerodermia, he, (the President) referred to this case. The youth showed the atrophic form of morphœa on the chest, and at the present time there was no sclerodermia in that part of the skin; in fact, the skin was thin, atrophied, and soft; but in the deltoid and triceps, especially on the left side, there was a perceptible hardening. The condition had cleared up to a certain extent under treatment. On the chest the skin would be seen to be much atrophied. An interesting point was that these cases of morphœa were sometimes reported as cases of primary atrophy of the skin. The case illustrated that even in morphœa atrophic changes might be very marked; although they classed sclerodermia as hypertrophy, it was really an atrophy. Such cases as the present went far to show that the superficial morphœa and deep sclerodermia were but variants of the same process.

Dr. Savill thought there might be a certain amount of myositis present. There seemed no reason why the fibroid change in the skin should not spread to the muscles.

The President agreed that the process went quite deep, sometimes even into the muscular tissue.

(2) A young child, the subject of *Lichen scrofulosorum* in an extreme degree, with a certain amount of Lichen pilaris—little horny pegs in the orifices of the papules. Lichen pilaris occurred as a complication of Lichen scrofulosorum and the miliary Syphilide as well as independently. Extreme cases of Lichen scrofulosorum were somewhat rare. There was some evidence of tubercle in this patient, but the regular scrofulous symptoms were absent. A sister of the mother died of consumption, and the husband suffered from it.

(3) A typical example of *Leucoderma*, but not very extreme in degree. It was most marked on the sides of the neck. At this time of year the collateral excess of pigmentation was not so marked as in the summer.

Dr. Savill showed a baby and its mother. The child was four months old, and three months ago it developed eczema, first on the face, then spreading to the body and legs. It was the usual vesicular type. The child also presented a patch of inspissated serum on top of the head, which had also existed almost from birth, and from which the general eczema had apparently spread. In consequence of

this he examined the mother, and found she had well-marked seborrhœic dermatitis of the head. Apparently the child had taken the disease from the mother. He thought it showed that seborrhœic dermatitis could be converted, in children, into an ordinary type of eczema, and it was to get opinions on that point that he brought the cases forward. He also regarded the case as an example of infection from mother to child. Seborrhœic dermatitis of the scalp was very much commoner than people thought. Both mother and child had been under treatment, and so the patch of sebum could not now be seen, but the mother still presented marked pityriasis of the scalp.

Dr. Arthur Hall said he was interested to see Dr. Savill's two cases, for he had lately seen two similar cases of apparent infection of children with seborrhœic eczema. One was a woman, subject to attacks of seborrhœic eczema, who had an outbreak on the hand and side of the head. Her child, which was born about the time, soon acquired seborrhœic eczema of the head and face. The second case was still more striking. A patient in the hospital with one of the most severe cases of seborrhœic eczema he had ever seen; it practically covered her body. She got better, and he was written to to ask whether the disease was infectious, and whether the young woman could take a place as servant without risk. He replied that he thought she could safely take the place. Shortly afterwards he was asked to go and see, in consultation, a child with seborrhœic eczema of the head. To his surprise, the girl who opened the door was his former patient. It appeared that the girl went to the home as housemaid, and that the outbreak in the child occurred shortly after the young woman commenced her duties.

Papers.

Mr. Campbell Williams read a paper entitled:—

CONGENITAL SYPHILIS: A NEW THEORY.

The question has appealed to me forcibly why, in congenital syphilis, when the child is born apparently healthy, does one so frequently meet with the *first* dermal or condylomatous signs of the disease at about the eighth to tenth week after birth, or, in other words, of separate existence. This period corresponds roughly to the time when one notes the appearance of rashes in the acquired form. Examination of the mothers of children who are of this degree of syphilis, usually fails to disclose any indisputable evidence, past or present, that they have suffered from the complaint. By the term "evidence" I mean those orthodox signs which are admitted by everyone to be of

syphilitic origin. But I have noted, on closely questioning these mothers, that the bulk allow that their health has not been so good after conception as it was before that event. The usual admission is that they are either not so strong, tiring easily, are listless, or have lost weight. Their complexions are as a rule sallow, muddy, or anæmic, and their hair is dull and lustreless. They always look "below par." Each and all of these signs may occur apart from any syphilitic taint, but it is a remarkable coincidence how frequently they are present in mothers who bear children that turn out to be congenitally syphilitic, and, what is more to the point, how they improve when mercury is administered to them. In the *degree* of congenital syphilis to which I am directly referring, the child is born apparently healthy, and remains so for about three weeks—a period equal to the incubation of the acquired form. Their health is then noted to gradually fail in the well-known manner. Now, it has been held that when a mother bears a congenitally syphilitic child, and yet shows no sign of the disease herself, that through being infected by the medium of her embryo she obtains, if not an immunity, a modified form of the disease, which does not extend in the same degree to the child *after* birth. My view of the reason why the child shows no signs of syphilis at its nativity, is, that whilst it is "in utero" its tissues are practically an integral part of its mother's, and share in that agency, whatever its exact nature may be, that keeps in abeyance the outward and visible signs in the mother. This influence is presumably a circulatory one, and a reasonable deduction is that it is some substance in the maternal blood that not only keeps in abeyance all symptoms of the disease, not only in herself, but likewise in her fœtus. So long as it is subject to this influence, it shows no objective sign, but when it gains a separate existence and is consequently removed therefrom, the virus, latent in its system, assumes a slowly progressive activity. It is almost as if the infant had come into the world charged with a maternal dose of antitoxin sufficient in amount to mask for a time the true state of affairs, and that its own rapidly growing tissues failed to continue its manufacture. The natal equilibrium is not of long duration, for a gradual decrease of this controlling power apparently sets in from the day of birth. It is remarkable how often the signs of this exhaustion first manifest their presence during the third or fourth week of life. The question that arises to one's

mind is, "What influence is at work that thus renders the child apparently healthy, both at birth and for a short period afterwards? It would appear as if the very act of birth was equal to one of inoculation, and if in these cases the mother has been infected through the medium of her embryo, she at least in her turn bestows upon *it* a protective influence that not only exists during fœtal development but persists for a short space of infantile life. It is as if the degree of syphilization of the child at birth represented that of the mother who gave it life, with this difference, that although both are the subjects of the same poison its subsequent activity is unequal. One notices that the specific taint of infants born of syphilitic women is in direct relation to the virulence of the disease in the mother. The *first* degree is where the fœtus is aborted before maturity, the *second* when it is born, either alive or dead, with syphilitic manifestations on its body; the *third* when these appear almost immediately after birth; and the *fourth*, the degree in question, when a period of apparent health elapses before their evolution. There is still a more protected form, in which the first *noted* signs, such as ear or eye trouble, may be years after birth. But we must bear in mind that recognition of a condition does not exclude the possibility that the child may have had earlier symptoms which were overlooked. Now modification in the mother is liable to an exacerbation which may not take place until many years after infection. Most of us have seen ulceration of a gummatous nature in the region of the knees of women of or near middle age in whom one fails to find or elicit any past *personal* history of syphilis, and of which this ulcerative lesion is apparently the first definite and recognizable sign. Whether you choose to call this condition one of latency or modification does not affect the fact that, for some reason or another, they have for years enjoyed an immunity from the grosser consequences of the disease. What agency can be at work that checks the activity of the disease in these cases and in the pregnant woman and her nascent offspring? In the latter, unless the maternal blood provides some corrective influence, it is difficult to conceive how the product of union of a tainted spermatazoon with a healthy ovum, if such it be, can in its development evolute a virus that has the power of infecting the mother and her fœtus in an *equally* modified degree, so long as they are an integral part of each other, and yet acts so unequally on the child

when that partnership is dissolved. Surely it cannot be that the developing ovum manufactures this modifying product for itself *only* so long as it is "in utero," and ceases to possess that power at the end of fœtal life. It would appear more reasonable to think that it is the mother who supplies it for herself and fœtus, as the latter seems incapable of so doing when it gains a separate existence, judging from the evolution of its post-natal syphilitic signs, whereas the mother remains practically in "statu quo ante." Since we do not know for certain what is the nature of the syphilitic virus, we cannot say that it is a living micro-organism, however much we may feel inclined to believe that theory. It is difficult to conceive that the progressive after-effects of an infinitesimal syphilitic inoculation can be due to a substance that has not a multiplying function—a living organism that has the power of propagating its species. And we must admit that under specific conditions, of which we are ignorant, that the potency of this inoculation, both in the acquired and the hereditary form of the disease, varies within wide limits.

This would lead us to consider what may be the causes that might possibly induce a modification in the virulence of syphilis. For purpose of simplification, I exclude the side issue as to whether there is any difference in the degree should the disease be due to direct infection, when the father suffers from a modified attack, or to indirect contamination through the medium of the embryo. The conditions necessary for such a state of modification would seem to be governed by one or part of the following factors:—That *before* infection the tissues of the host are unsuitable for the full development of the disease, owing either to their containing some substance which is antagonistic, or to their lacking something that is requisite to its evolution; or, conversely, that they gain this property subsequent to infection. If we consider the mother and her fœtus as one conglomerate body, subject to the same circulatory conditions, why is it that the disease becomes noticeably active in the child after birth, when its tissues are distinct from those of its dam, but yet remains unaltered in the mother? One would be inclined to deduce a favourable soil for development on the one hand but not on the other. That the tissues of an individual do seem to exercise some bearing can be inferred from the difference in the severity of the symptoms in two distinct people syphilized from the same source within a short

period. The most plausible explanation of the unequal gravity of the subsequent symptoms would be found in the power of resistance of the tissues themselves to the poison or the readiness with which they react to an antitoxin, rather than in a difference in the quantity or quality of the initial virus. This latter would mean that the power for manufacturing a toxin, both as to amount or potentiality, varied from day to day with a germ's own inherent vitality. We know that attenuation of virulence is met with in epidemics of other diseases, and that the severity at the end of an outbreak is of less intensity than that of the commencement. Women who are the subjects of this modified type of the disease will usually be found to have been infected by men who have either been very lightly, *but* recently, contaminated, or else by those who can long antedate the contraction of the disease. This suggests the idea that the infective strength of the virus is *not* a constant quantity, but is subject to attenuation, and that it is either primarily weak, or becomes so by the lapse of time. If this be true, then it is all the more difficult to explain why two people infected about the same time by the same woman have the disease in different degrees of severity, unless it were that their tissues exercised some direct controlling power over the subsequent development of the malady; for the strength of the infecting virus is *presumably* equal in both instances, and *not* therefore primarily in one case weak. It would appear, then, that when a lightly *but* recently infected male, or one that has long been syphilized, passes on the disease, either by direct or fœtal infection, so that the recipient evolves even a more modified type of the complaint, that this modification may be due partly to the inherent weakness of *his* virus and partly to the inimical resistance of *her* tissues. That these either create directly, or favour indirectly, the creation by the *infecting medium* of some substance which controls the progress of the disease. This agency seems to be of a circulatory nature, and extends to both the mother and her fœtus "in utero." That it is probably of maternal manufacture, in that whilst the state of control apparently persists with the mother, it does not in the child after birth, as is verified by the subsequent dermal or condylomatous signs that it exhibits, and that the *growing* tissues of the infant are, unaided by medicine, powerless to check the headway of the disease.

Discussion.

Dr. George Ogilvie (introduced) said he had much pleasure in listening to Mr. Campbell Williams's paper. The theory which he had advanced might, or might not, be correct. He would like now to make a few remarks about the behaviour of the syphilitic virus in pregnant women who were distinctly syphilitic; that is, in women in whom there was no vague history of syphilis months or years ago, but who, during pregnancy, and at the time of delivery, were in the full secondary period. Many things happened to the fœtus in these cases:—

(1.) The woman might abort.

(2.) There might be a premature birth.

(3.) The child might be born at full term, either dead, with marks of syphilis, or dead without any marks of syphilis.

(4.) It might also be born alive with signs of syphilis, or be born alive, and apparently healthy, and develop signs of syphilis within a few weeks after birth.

(5.) It might also be born alive and healthy, and remain healthy, *i.e.* as far as syphilis is concerned, during the whole of its life.

This last fact was so startling that, as long ago as 1865, Profeta made the statement, that a child born healthy of a mother showing signs of active syphilis, might be suckled either by its own mother or by a syphilitic wet nurse with impunity; in fact, that the child was immune against syphilis. Unfortunately, like many, or indeed all so-called "laws" in medicine, there were exceptions, because, as is now well known, such a child is liable to infection. He knew of a case in which infection took place as long as nearly three years afterwards. He had also collected cases in which infection took place from one or two weeks after birth, to one, two, or eight months. It seemed therefore difficult to form any idea as to how long the antitoxin effect referred to by Mr. Campbell Williams lasts, and he could not therefore give his support to the theory advocated by him.

Syphilis was, however, not the only disease which behaves in this erratic manner. In small-pox, for example,—as he had already pointed out in a note to a paper on "The Exceptions to Colles's Law,"—the transmission of small-pox from mother to fœtus is of an equally erratic character.

(1.) The child may be born dead with or without small-pox.

(2.) The child may be born alive with small-pox.

(3.) The child may be born apparently healthy, and develop small-pox shortly after birth (say two days).

(4.) The child may be born healthy, and either remain healthy or contract small-pox in extra-uterine life; in the latter case it almost invariably dies; to protect it it has to be vaccinated, which can be done successfully.

(5.) The child may, during an epidemic, contract small-pox *in utero*, the mother, who was vaccinated previous to gestation, escaping.

(6.) Of twins one only may be born with small-pox.

It seems that while intra-uterine transmission of small-pox is by no means rare, intra-uterine immunization very seldom takes place. Small-pox occurring during pregnancy is in a large percentage of cases instrumental in producing abortions and still-births. In the majority of such cases the fœtus shows no signs of actual or past disease. Still, eruption or scars indicating intra-uterine infection may be found on the dead fœtus, as well as on the living child, at the time of

delivery. The child, if born free from the disease, and remaining healthy, is neither refractory to small-pox nor to vaccination.

It will be seen, therefore, that there is a somewhat striking similarity in the behaviour of the virus of syphilis, and the virus of small-pox. We can say nothing definite about either of them, and in the meantime we must content ourselves with recording simple clinical facts.

Dr. PAYNE said the paper was a very interesting one, and raised an important point in the pathology of syphilis. It had long been known that in a great number of cases the infant was born without any marks of the disease, but began to display it a certain number of weeks after birth. On the other hand, when the child was born with the disease, it was mostly in a severe form, such as the so-called but badly-named pemphigus. Other cases were so marked that a friend of his had propounded the ingenious theory, which he was afraid would not hold, that these cases of so-called congenital syphilis were not congenital at all, but chance inoculation at the time of birth. This view could hardly be accepted, because it would not account for the other class of cases. Moreover, the outbreak of syphilis a few weeks after birth was not exactly like a secondary outbreak in the acquired disease; there was very seldom a general diffuse rash, and it was mostly of such an abnormal type that some authorities, such as Dr. Bristow, declared that all hereditary syphilis was of the tertiary type, which again he regarded as a great exaggeration, although there was something in it. It appeared as if some influence or other kept the syphilitic virus in abeyance for some weeks after birth, and then it began to come out, although, perhaps, not in a typical form. He might remind Mr. Campbell Williams that the subject had been discussed by Baumgarten, whose idea was that the fœtal tissues had the power of inhibiting the growth of micro-organisms, in which respect he likened syphilis to tubercle. He (Dr. Payne) did not know that anyone had previously put the matter in the same way as Mr. Campbell Williams, and suggested that it was a part or sequence of the maternal immunity. With regard to maternal immunity—Colles's law—Dr. Ogilvie had written on that subject; but, as far as his experience went, the frequency of maternal immunity had been greatly exaggerated. Some years ago he published, in *St. Thomas's Hospital Reports*, a certain number of cases of congenital syphilis; and he was surprised to find that in the majority of those cases the mothers had had clear signs of the disease in their own persons. He did not say it would always be so. Whether the immunity of the fœtus during fœtal life was due to the property of the fœtal tissues, as Baumgarten would make out, or whether it was due to an antitoxin prepared by the mother and sent through the placental circulation, as Mr. Campbell Williams supposed, he did not undertake to say.

Dr. JOHN SHAW-MACKENZIE (introduced) said he had been attracted by the title of Mr. Campbell Williams's paper, and as he had been engaged in working on the subject for some time past, and a publication of his (Dr. Mackenzie's) had been criticized very kindly in many quarters—not so in all—he hoped he might be allowed to make a few observations. He was particularly pleased to hear Mr. Campbell Williams, because what he had read coincided almost absolutely with views he had himself expressed. In the first place, he mentioned the question of immunity, and that he often found that mothers of syphilitic children were not absolutely immune. He agreed there were very few of such mothers who did not show some symptoms of ill-health about them, although these were not ostensible

signs of syphilis. Mr. Hutchinson had undoubtedly laid it down that 50 per cent. of the mothers who bore syphilitic children did suffer from some symptom or other; and if they referred back to Whitehead's very valuable work they would see it stated that there was hardly a mother of a syphilitic child who did not show some symptom of pelvic trouble during life—by pelvic trouble meaning uterine erosions and leucorrhœa, &c. In all such cases Whitehead had examined, the mothers were free from *outward* manifestations. He (Dr. Mackenzie) had recently attempted to show that the immunity of mothers was not real; that when the mother became pregnant a second or third time, she was often placed in the same condition as if she was in the secondary stage of the disease. Another point which Mr. Campbell Williams brought out, and with which he (Dr. Mackenzie) agreed, was that a mother in later life might show syphilis without having had a single symptom before, which was proof that she was not immune. Indeed the menopause was a very fruitful time for women to show symptoms, and both at subsequent pregnancy and at the menopause previous symptoms seemed to become lighted up after previously acquired disease. In looking over the history of syphilis, it was extraordinary that the more one read the more one found how little in connection with the disease had not previously been mentioned, by one authority or another. He (Dr. Mackenzie) had a large collection of books which the late Mr. Henry Lee had kindly given him, and many views which he thought had been advanced as new, and which he also pleaded guilty to, had been referred to in some shape or form by some one or other. The theory arrived at independently by Mr. Campbell Williams had, he thought it only right to mention, been previously put forward. Mr. Arthur Ward—he thought in the *Lancet* two or three years ago—thought that the toxins manufactured by the germs (if such there were) of syphilis in the fœtus were got rid of in the circulation of the mother, and that when the child was born its toxins could not be absorbed or dealt with by the mother, and showed themselves in syphilitic eruptions and other symptoms.

Dr. Coutts also, in his Hunterian Lectures, dwelt on the subject, and added that the antitoxins of the mother which were present during pregnancy were pumped in and out of the fœtus, and consequently mitigated the activity of virus in the child, and that therefore, when the child lost that antitoxin, the virus became active; at all events until such a time that it could manufacture its own antitoxin. Whatever the real process, it has generally been said that the mother was immune through the fœtus she bore; but he (Dr. Mackenzie) had thought she was immune on account of processes in herself; that the phagocytosis of full pregnancy, and the process of involution and lactation did put her in a position of partial or full immunity, and did clear off manifestations of syphilis from her. He thought this point worthy of consideration. The fact had been mentioned often enough that a woman after delivery did not show symptoms after previously acquired disease.

As to attenuation of virus there were two forms, one by time and the other by "soil," and it was important to bear them in mind. He would like to make one observation on Profeta's law referred to by Dr. Ogilvie. It was thought the immunity conferred upon the child lasted for two or three years only, and Dr. Ogilvie mentioned cases of syphilitic children who later had acquired syphilis. The question is, what was the nature of the syphilis they acquired? The question of hereditary immunity and attenuation has been a bone of contention. The late Mr. Henry Lee thought some people never caught syphilis at all, while others only

had it in a modified form. He pointed out that some patients actually required mercury for their cure, while others did not. We were, said Mr. Lee, bound to inquire the reason, and not therefore put it down to mere idiosyncrasy. The theory he propounded, which was to some extent founded upon the original theory of Fergusson in Portugal, was, that there was an acquired hereditary immunity, and that the virus became spent by self-exhaustion. That has been taught in the text-books, and has been testified to independently. Cases in support of this were first mentioned by Mr. Hutchinson in his work on "Syphilis," cases being given in which nothing was acquired but simple soft sores in after life; though he qualifies them by mentioning another case in which a congenital syphilitic had acquired a most virulent form. His modified cases as well as attenuation have recently received absolute support, and anyone reading the "Transactions of the Third Congress of Dermatology" must be compelled to acknowledge that the question of hereditary immunity and attenuation was no "myth," "fable," or "comforting" hypothesis, but absolute fact. He invited members of the profession to give attention to the point and to satisfy themselves, and to especially consider the facts of Professor Tarnowsky.

Mr. Campbell Williams said he had little to state in reply to the discussion. He would pay Dr. Radcliffe-Crocker the compliment of having years ago pointed out to him the fact that women of middle age developing gummatous ulceration as the first *noted* sign had been undoubtedly syphilitic for years, even though there was an absence of history. It was that which induced him to work at the subject, and he had seen several instances at the Victoria Children's Hospital of mothers who had borne children that eventually showed signs of congenital syphilis in whom no trace of syphilis was present. He was very sorry if he had trenched on anyone else's ground, but the views expressed in his paper were his own. He knew Mr. Ward had written on syphilitic antitoxin, but was not aware that Mr. Ward had advanced the idea that it was a maternal manufacture of antitoxin which not only protected the fœtus *in utero*, but *also the child* for a short period of life *after birth*. He thought his own contribution was an addition to Mr. Ward's antitoxin theory, in that it went to show that *the growing tissues of the infant seemed incapable of manufacturing an antitoxin for themselves.*

Dr. Arthur J. Hall (Sheffield) read a paper entitled:—

REPEATED ATTACKS OF ECZEMA PRODUCED BY PHENYL HYDRAZIN HYDROCHLORIDE.

Mr. X., æt. 30, an unemotional, athletic Scotchman, previously quite healthy, and with no hereditary tendency to skin affections, began during July, 1894, to suffer from a slight eczema limited to the fingers. He was, at that time, as he is now, demonstrator in a chemical laboratory. He took little or no notice of this local eczema, and during the long vacation, which commenced soon after, the fingers got quite well. On resuming work in September, 1894, he had a similar attack. This work was not his class-work, which did not begin till October, but a research in organic chemistry, in which the reactions of phenyl hydrazin, glacial acetic acid, and various urea derivatives were being studied. Under

medical advice he reduced his laboratory work as much as possible, confining himself solely to his necessary duties there, supervising the students' work. He also took much more active outdoor exercise. During the winter of 1894-5 he remained quite free from attacks, and was able to take his ordinary classes. At the beginning of the Easter vacation, 1895, he resumed his research work, the only materials common to this portion of it and the work he had been engaged upon in the September previous being phenyl hydrazin and benzaldehyde. One day, soon after he started, considerable vapour was given off from his experiments, and the same evening he began with a severe attack of acute eczema, chiefly affecting the *face*, *neck*, *ears*, *hands*, scrotum, and thighs. This again compelled him to give up his research, and he steadily but slowly improved from this time till the end of term. Directly he started research work, however, he had a fresh outbreak. His medical attendant recognised that his laboratory work was the cause, but as this was his sole means of obtaining a living, the prospect seemed very bad. During the long vacation, 1895, he got quite well. On resuming his research with phenyl hydrazin and benzaldehyde he had another bad attack. He never touched his research again till December, 1895, when, thinking he must now be all right, he started his research again, using phenyl hydrazin alone; in doing so, he upset some on his left hand. The hand began to burn at once, and within two hours his fingers and face began to itch, and by evening he had his worst attack, widely spread as ever. Having thus accidentally found out the irritant which started the trouble, he gave up handling or using phenyl hydrazin himself at all, and had no further attack, although working in the chemical laboratory every day during terms. He remained quite free from eczema from December, 1895, until November, 1896, when one evening he began with another attack, and on making inquiries he found that some phenyl hydrazin had been used in the laboratory by a student without his knowledge, and contrary to his orders. The attack quickly subsided. The history is not yet quite complete. He kept quite free until July, 1898, when, wishing to continue his research, which promised some very interesting results, and finding that it was necessary to use phenyl hydrazin again, he gave full instructions to his laboratory assistant as to what to do, whilst he himself went into an adjoining room not connected directly with the laboratory, and remained there whilst the assistant carried out the work in the laboratory. When it was completed the assistant came to him in the other room to tell him the result, and stopped talking to him for a few minutes. He himself did not go into the laboratory again that day, but surely enough he began with an attack of eczema during the same evening. In this attack the eyes were chiefly affected, and there was great œdema of the face—the thighs slightly, and the hands very slightly. The vapour had undoubtedly clung to the clothes of the assistant, as the further history shows. For, whilst convalescing from this attack at home, the laboratory assistant, who had been continuing the work during his absence, came up to his house, a distance of one mile, to see him, and stayed talking about ten minutes—with the result that he had a relapse the same evening.

I should like to call the attention of the Society to one or two points which appear to be of interest in connection with this case.

In the first place, until the patient himself isolated the irritating

cause, it seemed to be a case of severe recurring eczema, and he was thought to be overworking, and advised to take more exercise and get more fresh air. Since he has found out the cause he is able to continue long hours of work in the laboratory without his health suffering in any way. In other words, the exact irritant being unknown, it was conjectured that ordinary slight irritants which do not affect the multitude produced eczema in him because his neuro-cutaneous reflex was too susceptible, owing to general overwork. Had he happened to have been the Demonstrator of Biology who works on the floor above, and had he received the irritating fumes of phenyl hydrazin as he passed the door of the Chemical Laboratory, or had he even been less observant than he was, it is quite possible that, the cause of the eczema remaining unknown, he might have had to give up his duties and live elsewhere, and then probably the much-maligned atmosphere of Sheffield would have received the blame, and so added one more to its much over-exaggerated evils.

In the second place, this case enforces very strongly the fact that a purely local irritant may and does produce a wide-spread eczema. In Mr. X.'s fourth attack, December, 1895, the history is very clear on this point. In the afternoon he spilled a little on his left hand, the place began at once to itch and burn, and within a few hours he had a severe outbreak widely-spread over the face, ears, and neck, both hands, scrotum and insides of both thighs. There is here no possibility of its having spread by continuity, for the positions are widely separated from one another, nor is it fair to argue that possibly the vapour had affected the other parts. That might be true as to the face and neck, but would hardly apply to the insides of the thighs. It seems to me that this is an ordinary example of what occurs in reflex actions: if the stimulus is slight and of short duration there is a local response, if the irritation continues, the associated nervous centres are roused, and if it is sufficiently prolonged, quite distant nerve-centres become active, as in the example of the decapitated frog's foot placed in dilute acid, or the violent fit of coughing following prolonged irritation of the larynx.

Thirdly, in cases of eczema where we say "the skin has acquired a bad habit," or, as it has been said, "where the skin remembers," it

does not remember with pleasure, but becomes short-tempered; in other words, the neuro-cutaneous reflex, which was at first fairly tolerant and only responded locally, later on rouses other centres, or, I should say, the rest of the neuro-cutaneous reflex, to activity, and at last the whole reflex is roused by the merest trace of the irritant.

In speaking so much of the irritant, I have no intention of forgetting the "irritated." My patient's reflex suffered from the presence of phenyl hydrazin, nobody else in the laboratory did, therefore we may consider that his reflex was in that respect not absolutely healthy, but no other irritant has as yet appeared to call forth this reflex; cold winds, soaps, water, &c., produce no eczema; though, of course, they irritate him during his acute attacks.

In conclusion, I beg to thank the patient for his kindly furnishing me with this interesting history, and also Dr. Sinclair White, under whose care he was, and for whom I saw the patient during the holidays, for permission to record it.

Discussion.

The President said they all noticed that some irritants would excite dermatitis in some but not in others. There were also irritants which would cause dermatitis only in persons who were peculiarly sensitive; in which connection he instanced an example of iodoform eruption. It was, however, puzzling to understand how the disease could be conveyed by an individual coming half a mile from the laboratory to see the victim of the disorder. He thought Dr. Hall raised a very important point. Some people drew a very hard-and-fast line in their definition of eczema—viz., an inflammation which was not excited by local irritants. He thought that was far too narrow a definition. Although there were some cases of irritant dermatitis which they could recognise at once as due to irritants, there were a large number of cases in which it appeared to be absolutely indistinguishable from ordinary eczema, although it was really of local origin. Even local irritants produced generalised results.

Dr. Payne said he entirely agreed with the latter part of Dr. Hall's paper, and with what the President had said about it. Local irritants sometimes produced local dermatitis, but sometimes they caused a true eczema. He himself had a slight tendency to eczema, and he once produced an outbreak of it by poulticing one hand. Shortly after there was a patch of eczema in the corresponding position on the other hand; which could not have been from local extension, but must have been referable to the nervous reflex.

Dr. Arthur Hall, in reply, said he had read the paper in the hope that it might have formed an occasion for a discussion on eczema. He thought it illogical to

call these cases traumatic dermatitis rather than eczema. The man was rightly considered to have eczema before the irritant was discovered.

It then answered all the requirements of an eczema—viz., it was recurrent, vesicular, occupied definite positions, and there was no apparent cause for it. If, directly they found out the cause of a case of eczema, they were to call it dermatitis, there would presumably come a time when all the causes would be discovered, and then there would be no eczema left.

Wednesday, January 25th, 1899.

A MEETING of this Society was held on Wednesday, January 25th, the President, Dr. H. RADCLIFFE-CROCKER, in the chair.

CLINICAL CASES.

Dr. ABRAHAM showed (1) a man, the subject of a typical Duhring's *Dermatitis herpetiformis*. The man had been in bad health since last winter, and about August some spots appeared on one shoulder. Shortly afterwards he became very ill, and suffered from severe retention of urine. Then patches appeared on his back and elbows and arms. Three or four weeks ago those patches were erythematous; there were also papules and small vesicles. After about a week under treatment at the West London Hospital the bullæ were very well marked, but they had now nearly disappeared, leaving only patches of erythema symmetrically disposed. The prominent symptom was extreme pruritus and burning. As these cases were rare, he thought it would be of interest to the members to see the patient. Curiously enough, he had a patient ready to show who had the same disease, and who had a recurrence quite recently. It was well known to be a recurrent affection, and as a rule was difficult to treat. Still, the five or six cases he had had responded to treatment. He called special attention to the point insisted on by Duhring—viz., the herpetiform arrangement. It was formerly called hydroa. The patient's urine still contained albumen.

Dr. STOWERS said the patient reminded him of a case he had under care two years ago, which had one or two symptoms in common with it. That patient also had retention of urine, and for a long period subsequently albumen was present in the urine. These facts were interesting, seeing that dermatologists were not in a position to explain, as they would, the whole pathology and etiology of the affection. He suggested that it would be better to avoid, at present, the use of the word "typical" in relation to the disease, as it was seen under a variety of conditions and characters.

Dr. EDDOWES asked whether there was any alcoholic element in the case to account for the neuritis. It would be of interest and service if the Society were to collect evidence about the distribution of these striking nerve lesions. If they were

to do some collective work on a subject of that kind, they would be able to form valuable atlases of cutaneous nerve supply.

(2) A young woman the subject of *Dermatitis herpetiformis;* but the manifestations were now so slight that he would have to ask members to take his description of the facts. A few days after the birth of her first child, some months ago, she developed an eruption on both forearms, of an erythematous, papular, and bullous nature. When she consulted him in October the erythema was very marked, and there were also bullæ and vesicles. She also suffered from intense pruritus and burning pain. Some of the bullæ were broken and became crusted. She got well in two or three months, and quite recently had a stillborn child, shortly after which redness and papules appeared again in parts of the old positions. She now only had a few patches of slight erythema on the neck and face. If he had seen the case for the first time to-day in its present stage, and had not known its history, he would probably have regarded it as a seborrhœic eczema. The attacks did not appear during gestation, but after delivery. He at one time had the idea that it might be Impetigo gestationis, but the vesicles were too clear for that, and there was no outbreak on the abdomen, or anywhere except the arms, only a little on the face and neck.

The PRESIDENT remarked on the interest of these two cases. There was no doubt that the eruptions were practically identical. When once a woman had the eruption at pregnancy it was remarkable that, as a rule, she had a return at each succeeding pregnancy, coming on earlier and earlier, until at length it came to be regarded as the first sign of pregnancy in the woman. Usually there was a very severe outbreak after the confinement. He agreed with Dr. Abraham that the cases were extremely obstinate, and they could never know whether they were going to cure or only to mitigate them. Still, a great number of them did get well. A few of the cases, however, associated with pregnancy, persisted.

Mr. PERNET said that an interesting case of Herpes gestationis had been under observation in the Skin Department of University College Hospital for some years. The woman had had four attacks: the first occurred three days after delivery, and the other three at the sixth, third, and seventh month of pregnancy respectively. When she last attended, for fourth attack, he had, in the absence of Dr. Radcliffe-Crocker, put her on Salicin. Under this drug there had been marked improvement.

(3) A case of *Atrophodermia* in a female. The patient attended Blackfriars Skin Hospital, about two months ago, with macules on her back and chest—whitish, depressed, scar-like marks. As she had some spots of acne at the same time, he was inclined to look

upon them simply as acne scars, such as were often found on the back. But the patient said they did not follow pimples, having come spontaneously; and on closer inspection he found many of them were raised above the skin-surface, while others were somewhat reddish and more flat, with capillaries that could be seen with the glass. He therefore came to the conclusion that it was probably a case of what might be called Atrophodermia guttata. Such localized atrophies had been repeatedly described ever since Erasmus Wilson first drew attention to them. A remarkable, but not quite similar, case was published by Jadassohn. He had watched the lesions, and thought he was correct in saying that they commenced as telangiectatic maculæ, which were first swollen and raised, and then the atrophy ensued.

Mr. Campbell Williams said he had had a case which he was able to watch carefully. As a matter of fact he had marked out several acne pustules or comedones, and expressed them, and watched the result. The skin around the orifice was then apparently healthy. It had taken nearly four months for the atrophy to follow the expression of the comedones. There was certainly hypertrophy of tissue amongst several, as they were raised, constituting a hypertrophy rather than an atrophy. He suggested these lesions were slight overgrowths of tissue—in fact, adenomatous. Microscopical examination had not been made because patients were not very willing to have lesions removed. It did not seem to him that it was all atrophic scar tissue, and he would like to hear the President's opinion.

The President said he thought there was an overgrowth of scar tissue. The present case was open to two interpretations, as Dr. Abraham himself had said. Either it was a thickened scar consequent on the acne from which she still suffered, or it was Atrophodermia maculata. He (Dr. Crocker) was disposed to look upon it as acne scarring, especially as it was in the acne regions, and as she had suffered from acne for many years. Moreover, Atrophodermia maculata was very rare, and if the evidence was nicely balanced it was generally safe to regard it as the common rather than the rare condition. Of course, if Dr. Abraham had watched it develop that was another matter; members could only discuss it as they saw it now.

Dr. Eddowes said he considered this case to be one of Folliculitis necrotica, a disease which was not described in English books. He showed last year before this Society a lantern slide of a case; and had shown on two other occasions a patient suffering from the affection. The mouths of the follicles were affected; there was no deep acne, but a little atrophy or necrosis was always produced by the small pimples or crusts which formed in the mouths of the follicles. The disease was well described in one or two of the more recent books on the Continent. Leistikow mentioned it in his little book, and Brocq has given an excellent clinical description of it.

Dr. Savill showed (1) two cases for diagnosis in two girls,

unrelated, both 10 years of age. One of the patients had the affection mostly on the legs, back and buttocks, and it had been in existence about four months. Each little papule was hard, the size of a millet-seed, and was covered by a tiny scale. The extensor surfaces were the parts chiefly affected, but not the elbows and knees. The subjects were feeble and anæmic. The other child had got a little different history, and a different distribution, as well as having another kind of lesion. This second case was probably *Lichen scrofulosorum.* Ten months ago she had an outbreak on the face, and six months ago she had a similar outbreak, also on the face; four months ago the disease came on the hands, and she had practically had none anywhere else. The lesions came out in crops, and had existed as little hard papules, some of which became vesicular on the top and dried into a firmly-adherent scab. It was confined to the extensor surfaces of the hands, wrists, forearms, and face. The eruption had almost faded, and what was left was chiefly on the face. There were also little papules which, in most cases, had become vesicular and dried into scabs. None of them had been pustules, so far as he had seen.

The PRESIDENT said that although the second case at first sight looked like a tuberculide, he considered it a case of Psoriasis punctata. It was extremely like at first sight the tuberculide he had described as Acne scrofulosorum, which often came out on the buttocks and extensor aspect of the upper arms, as in a recent case at University College Hospital. On looking into some of those spots and scratching them carefully, bleeding points could be seen, while in others there was a silveriness. The other case he confessed he could not make out; there was not enough of it to make a diagnosis from.

(2) A young woman, æt. 19, who presented a purpuric condition affecting the arms and legs. Little flat spots came out in crops, and had done so for six years. When 13 years of age she jumped into a swimming-bath after she had been perspiring freely, and thought she got a cold. She was laid up for some weeks, and while she was ailing these spots began to come out in crops. Their size varied between that of a millet-seed and a split pea. They were evidently purpuric, leaving behind freckle-like stains distributed over the legs and arms. It had a remarkable symmetry. The other elements consisted of large patches of purpuric staining, like, as someone had suggested to him, a tar eruption. This second element had dated from her treatment with chrysophanic acid ointment. She had only had this

treatment for a limited time. The region affected was limited by a line at the back. The texture of the skin was everywhere flat and smooth, excepting here and there small telangiectases and small streaks of atrophy. The skin got darker from time to time. She had had no treatment which was likely to cause this. There was no itching. The condition was worse in the winter than in the summer.

THE PRESIDENT said a case was attending at University College Hospital some time ago—a young woman—and who for ten years had been the subject of purpura of the legs, and as a consequence of the repeated attacks, her legs became deeply pigmented, and were a deep sepia from the knees downwards. If she was standing much she had attacks almost daily. The present case was, perhaps, a mild degree of the same condition. Pigment following purpuric spots was not at all unusual, especially on the legs, but it was remarkable that it kept on so long.

THE PRESIDENT showed (1) A case of *Lichen planus* in a man. He brought it forward because it was extremely typical of what the French termed classical Lichen planus, on not only his arms but his legs. The man had a chronic hypertrophic patch with great horny thickening on his leg for nine months. It often happened that after a time it began to generalize to some extent.

(2) A case of *Tinea circinata* on the wrist. There was a good deal of inflammation on the border when he first came under observation, but it was now improving under treatment. Some of the fungi—megalosporon—were under the microscope. He also showed a drawing of a much more extreme pustular ringworm, which had been described by Leloir as *agminated Perifolliculitis* without appreciating that it was due to tinea. Sabouraud had already proved that it was caused by a tinea in the skin. When first seen the border of inflammation in the present case was distinctly vesico-pustular all round. The patient had nothing to do with animals in his occupation.

Dr. STOWERS said he saw a case similar to the President's in 1889, and it was published as one of Leloir's disease in 1890 in the *Illustrated Medical News*, with a picture. The case corresponded very much in appearance with the present one, and the patient was associated with horses in general stable work.

Dr. STOWERS showed a female infant, æt. 10 months, the younger of two children, the elder having died of convulsions. He believed there was nothing in the history which would bear on the conditions

before them. The child had been vaccinated at the age of six weeks, and it was now thin and pale. Six weeks ago a swelling was noticed on the outer side of the left foot, close to the external malleolus, which proved to be of tuberculous nature. Pus formed, and the abscess was opened and scraped fourteen days ago. This occurred subsequent to local infection, a well-marked verrucose lupus having developed at the base of the right index-finger, which commenced about six months before. Two days after the abscess was opened an eruption was stated to have developed on the child's forearms and thigh and leg on the left side. He drew special attention to the eruption because the papules were remarkable; and the appearance was very similar to that of Lichen ruber planus. They were red, raised, flat and shining, with an angular outline, corresponding to the usual appearances of Lichen ruber planus. They were discrete in arrangement, but here and there two or three were aggregated together. A distinct line of demarcation was visible between them. They had also a tendency to linear arrangement. The trunk was free. There were no scratch-marks, and the child was stated not to have had itching. The point of interest was whether it was a lichen *sui generis*, or whether it was a modification of Lichen ruber planus, with which they were so much more familiar. He thought the present case was not one of Lichen ruber planus. He had a young lady patient in 1893 with a very similar condition (coloured drawing exhibited), which developed in a line down the inner side of the thigh and leg, and in four months disappeared spontaneously. There was no itching.

Dr. Stowers was of the opinion that the eruption in each case was a separate disorder, and was to be regarded *sui generis*.

THE PRESIDENT said he would not say that it was a case of Lichen planus. Possibly the eruption was a sweat-eruption dying down. In his experience, Lichen planus in infants was really not a true Lichen planus, but a miliaria in a declining stage. He had seen true Lichen planus in a patient as young as three years.

Dr. WALSH sent two photographs:

(1) *Favus* of the cheek in a young woman, in which the fungus had been found, and

(2) A primary chancre of the cheek, also in a young woman.

The PRESIDENT showed a microscopic preparation of large-spored tinea from his case (2).

Also the following coloured drawings :—

(1) Large-spored ringworm, *Agminated perifolliculitis.*

(2) Extreme case of *Leuco-melanoderma.*

Dr. ARTHUR HALL then showed a photograph of a case of primary syphilis with two hard sores on the hand, the patient being a midwife who had received the infection from a case she attended.

PAPER.

The PRESIDENT, Dr. H. RADCLIFFE-CROCKER, read the following paper, entitled :—

RECURRENT DESQUAMATIVE SCARLATINIFORM ERYTHEMA.

THE disease of which I propose to relate two examples is a rare one, but somewhat important, as it is liable to be mistaken for scarlatina itself. Very few cases have been reported in this country, probably because the disease has not received much attention from English writers, and such examples as have occurred have usually been misunderstood.

As far back as 1769 and 1770, Warner, the then senior surgeon of Guy's Hospital, reported two cases to the Royal Society, and presented cuticular casts of the extremities, which had been sent to him by practitioners in the country. Other cases have been recorded from time to time under various names, but we owe the clear differentiation of the disease to Feriol's (1876), Besnier's, and Brocq's writings, the last especially having given a very excellent historical and descriptive account of it in Vol. III. (1883) of the *American Journal of Cutaneous Diseases.* Brocq regards it as a variety of Pityriasis rubra.

I will relate the two cases, and then make some general comments on the affection as a whole.

CASE I.—*Recurrent Scarlatiniform Erythema.*—A. E. S., æt. 31, hospital nurse, was admitted into University College Hospital on January 1st, 1897, with

her fifth attack of a general exfoliating dermatitis. She stated that her first attack was in 1888, when a blush-like rash appeared, first on her face and thence spread over the rest of the body, and was followed by slight scaling. She was in bed for a month, and she has noticed that ever since her skin has been much rougher than it was before, and that it does not perspire. Before this attack her health had been good; she had never had serious illness, nor had she suffered in her joints; and even now her health is disturbed only during the attack. There is nothing noteworthy in her family history.

In 1892 she had the first attack exactly like the present one; it lasted about a week. She had three others between this and 1894, and from that time was free until December 24th, 1896, when her present attack commenced. On Christmas Eve she had a feeling of great lassitude and went to bed early; in the night she woke up with a feeling of heat and burning in the face and hands, and in the morning she noticed that her face was red. The redness and discomfort rapidly increased, and became general. Some dark, purplish patches were then noticed on the legs and thighs, and at the same time the joints became swollen and painful on motion. Her temperature that day was 100° F., and it has been 99° in the evening since. After a day or two the skin began to crack and peel.

On January 2nd the following notes were made:—The face is of a rather deep-red colour, but not so bright as it was yesterday; it is deepest on the forehead, where the peeling is less pronounced than on the cheeks, which are thickly covered with scales, so that at first sight it looks like slightly-crusted exudation, which is also present on the ears, but the surface has never been moist; the lips are only slightly affected at the extreme border. The tongue is rather thickly coated with a white fur, but there are no prominent papillæ. The front of the body is very little redder than the normal, except at the axillæ, but there is a branny desquamation over it very like an ichthyosis; it is crusted at the umbilicus. The colour has also faded on the arms, leaving only powdery desquamation, and some deepening of the sulci.

On the back of the hands the skin has completely peeled in large flakes, leaving a still scaly surface. The peeling is complete to the end of the first phalanx, the skin beyond it being in tatters at the border, but not yet peeled.

The palms are at present intact, but the sharp line of undermined epidermis at the wrist indicates that they will ultimately peel. The patient states that in previous attacks the skin has peeled *en masse* on the hands and feet, forming a complete mould of them, and that the nails also have come away at a later period. In this attack, however, they do not appear to be affected. On the back, the colour is normal, but it is very rough all over to the touch, covered with the branny "mealiness," and close examination shows a horny plug at all the follicular orifices, in some parts almost spiny, and resembling a Lichen pilaris; but nowhere are there distinct papules.

On the lower limbs the colour is also normal, but the thighs are covered with delicate adhesive scales, while below the knee the skin has peeled off in large flakes down to the lowest third, where the skin is loosening in large lamellæ. The dorsum of the feet is slightly reddened, but the process of exfoliation has already commenced. At the sides of the instep the skin is normal, but the soles are dry and hard, and will probably peel. The patient does not appear to have lost much flesh, though the muscles are somewhat flabby; the pulse is rather small, and the bowels are confined. She was not aware of having had a chill, or anything

definite as an exciting cause. Liniment of Dee oil and lanoline, with one per cent. of salicylic acid, was ordered to be rubbed into the body and limbs, to relieve the feeling of dryness and tension.

On January 4th it was noted that the patient had been very restless since the night of January 2nd, and that she complained of stiffness and tension in the skin, and shooting pains in the limbs. The pains commenced in the limbs and shot along the internal part of the limbs, and not in the skin itself. She thinks she has more pain than she had in previous attacks; the desquamation is increasing, the backs of the hands from which the skin had already peeled are becoming again scaly. The redness and desquamation are increasing all over. She was ordered Lassar's paste, without salicylic acid, for the face, and calamine liniment for the body.

Under this she improved. On the 7th the whole surface was paler, and covered with scales about a quarter of an inch square on the trunk and upper limbs; on the lower limbs the redness had also faded, but the skin was only beginning to peel in large flakes. The feet had not finished peeling from the first attack. On the 14th the face was still intensely red, but the desquamative process had become much more complete. Improvement continued until January 22nd, when the face, which had become paler again, reddened slightly, and the left leg was redder than the right. She said that the day before she had a slight feeling of twitching, such as usually precedes an attack. This exacerbation did not go on further, and by the 29th there was practically no scaliness of the trunk and limbs, except slight branniness on the upper part of the back, but there was slight redness of the legs and of the upper part of the face. There was dense scaliness of the scalp. The left little toe-nail appeared as if it would come off.

On February 3rd she shivered, and the rash again appeared on the 5th, and was very marked on the 6th all over the body, with a punctiform bright red erythema, the incomplete desquamation of the last attack overlying it. On the 8th she complained much of flushings, which lasted a minute or two; on the 9th she continued to feel unwell, feeling stiff all over, and it was difficult for her to move, and she felt as if she was going to have another attack, and the flushings were very troublesome. The desquamation from the previous attack was now completed. She was ordered salicin every four hours, beginning at 5 P.M. The next day the tension was less and she could move more easily, and the surface was not so red, so the medicine was reduced to three times a day. On the 10th the improvement continued; there was less tension and flushing, the urine was normal, the temperature was 97°. From this time she continued to improve, and was discharged convalescent on February 26th.

The temperature sheet has, unfortunately, been lost; but there was never much elevation of temperature.

CASE II.—Frank P., æt. 21, was admitted into University College Hospital on December 13th, 1898, with his third attack of this disease.

His first attack was in January, 1897, when he was in the Great Northern Hospital, and peeled all over.

His second attack occurred six weeks ago, and the present one began on December 12th; but he has felt very irritable for nearly a week.

The eruption began on the chest and went down to the thighs, but did not extend to the calves.

On admission a bright red eruption extended from one inch above the suprasternal notch, and round the neck on a level with the nucha all over the trunk, both back and front, and down the thighs as far as the knees, fading off behind, just below the bend of the knee.

On the back, the redness was nearly uniform, with slight follicular prominences; but in front, on the upper part of the chest, it is punctiform, like that of scarlatina.

On the upper limbs the eruption is chiefly on the inner surface, but there was a slight degree of it on the aspect of the forearms, while there is scarcely any on the extensor aspect of the arm below the deltoid.

The tongue was moderately coated with white fur, but the papillæ were not prominent. The fauces were slightly congested, but there was no marked enlargement of the sub-maxillary glands. The post-sterno-mastoid glands were slightly enlarged. The temperature was 99° F., pulse small, 100. There was a trace of albumen in the urine.

On the 15th the temperature touched 100·2°; on the 16th it was a 100° F. It fell below normal on the 17th; but all through there were evening rises and morning falls to the sub-normal, going once as low as 96°, and reaching a maximum of 99° F. on the same day.

The redness had faded considerably on the 16th, and peeling commenced in several places on the upper part of the body, while the redness spread down the legs, and reached the back of both feet on the 20th, attended with a good deal of irritation. By this time there was a distinct line of demarcation about the knees to below the poplitieal space, produced by the peeling, commencing from below upwards on the part first affected, while the part subsequently involved showed no sign of peeling. On the 21st the patient had a sudden attack of vomiting, without apparent cause, as he was getting back into bed, having only got out for a moment. On the 22nd branny desquamation was general, the skin on the back of the hands, wrists, and forearms, for three inches, was red and roughened, while the skin of the palms was of a brown colour; but it was not until the 22nd that the palmar surface began to come off in large flakes. He was discharged on December 31st.

Etiology.—The first attack occurs most frequently between 30 and 40, but no age is exempt. More men than women have been attacked, and Brocq says dry-skinned persons are more liable to it; my first case said that her skin had been rougher and drier, and that she had ceased to perspire after her first attack, so that probably Brocq has mistaken the sequel for the cause. I had a patient in whom an attack of scarlatiniform erythema, with elevation of temperature and desquamation, occurred just after three successive confinements. In one of them a diagnosis of scarlet fever was made by a physician to a fever hospital. Possibly this is not quite the same as the other cases, and is more allied to the scarlatiniform eruptions not very rare after some drugs, such as mercury, quinine, etc., or they may be all of the same nature with different exciting causes. It is not improbable that all the cases, except those from

drugs, are due to absorption of toxic products manufactured under varying conditions, which we can at present only guess.

Diagnosis.—The rapid and universal invasion with an erythematous efflorescence, followed by desquamation in large patches a few days from the onset, the tendency to relapse, and sooner or later to recur at intervals of months or years, are the most characteristic features. The chief difficulty would be to differentiate it from scarlet fever in some cases. In the absence of history of previous attacks the most important points are—the extremely short duration of the prodromal symptoms, the development of the rash not corresponding to the rule of scarlatina, the temperature not being raised so much as would be expected from the full development of the rash, if it were really scarlatina, and the abrupt commencement of the desquamation after three or four days in large flakes, and these would, if all the symptoms were taken together, render a decision possible. From the more typical form of Pityriasis rubra the non-persistence of the exfoliation in scales, and the relapses every few days, would make a differentiation, as well as the short course as a whole, whether with or without relapses.

Brocq considers that the cases of "deciduous skin," in which the patient sheds his cuticle wholly or partially at regular periods like serpents, are of the same nature as those we have been discussing—although many of them are of congenital origin; but this point cannot be discussed on this occasion.

The treatment is simple. A uniform temperature is important, rest in bed, and locally inunction with olive oil or other emollient, to relieve the tension of the skin, are the chief indications; and as the theory that the disease is due to a toxin is very probable, full doses of the perchloride of iron should be administered. In the first case salicin appeared to check a relapse, and there were none afterwards, so that it would be worth trying in future cases.

Discussion.

Dr. Savill asked what differences the President would draw between the affection just described and the Epidemic Skin Disease he (Dr. Savill) had described in 1891. The temperature, of course, was a point one would look at first, and it appeared that this was 100° to 102° at times, and during the rest of the time about 99° in the evening and subnormal in the morning. The majority of his (Dr. Savill's) cases were in old people, in whom one would not expect so much constitutional

disturbance, but when the disease occurred in people of 20 or 30 years of age there was a similar elevation of temperature, and the eruption had a very striking resemblance to that described by Dr. Crocker. Of course the President's were sporadic cases—there was no history of infection, at any rate they did not occur in groups. Two striking features, in which the President's cases resembled his own, were:—(1) that the eruption was generalized, and (2) the skin was shed practically *en masse;* it was an extremely exfoliative dermatitis. Reverting to temperature, in the cases of Epidemic Skin Disease which occurred at St. George's-in-the-East Infirmary the temperature was considerably elevated in some of the patients; not at all in others. In all the cases there was a great tendency to relapse. There was an outbreak in Whitechapel Infirmary, where the only point which puzzled the Medical Superintendent was the elevation of temperature, which was 103° and 104° in some instances. The disease was certainly just the same as that which he (Dr. Savill) had described; the cases being epidemic in the one case, sporadic in the other.

The PRESIDENT, in reply to Dr. Savill, said no doubt there were analogies between his cases and those which had been associated with Dr. Savill's name; but there was in his cases a great tendency for the attack to be prolonged by relapses, and to recur year after year. In a case under Dr. Tilbury Fox there were about 100 attacks in thirty or forty years. Again, his (Dr. Crocker's) were nearly all sporadic cases, and indeed they were very rare, but as far as the epidemic exfoliative dermatitis was concerned, there was nothing very peculiar about the eruption. The peculiarity consisted in the circumstances under which they occurred. The course of all the cases was very exactly identical. The scarlatiniform rashes were very difficult to diagnose unless they knew all the circumstances under which the cases occurred. Therefore, though he would admit an analogy between his cases and those described by Dr. Savill, he would not be prepared to admit the identity of the disease with epidemic exfoliative dermatitis.

Wednesday, February 22nd, 1899.

An Ordinary Meeting was held on February 22nd, 1899, Dr. H Radcliffe-Crocker in the Chair.

Clinical Cases.

Dr. Abraham showed a case of *Tinea tonsurans* of the scalp in an adult man. Certain authorities, especially abroad, had stated that tinea of the scalp never occurred in adults, but that was not the experience of dermatologists in this country, for, although the condition is extremely rare, some of us had occasionally encountered such cases. Dr. Aldersmith, who had had an enormous experience of ringworm, had come across three or four cases. The present case was the fourth he, Dr. Abraham, had seen since 1885. The first was in a woman, aged about 30, both of whose children he was at the same time treating for ringworm. Her case proved a most difficult one to cure. Another case happened at the Westminster Hospital, in a medical student of 21 or 22 years of age, in whom the scalp lesion was well marked; but he soon got cured. The third was in a woman, who had a sort of Tinea circinata at the nape of the neck, which spread upwards to the scalp. The present patient showed well-marked Tinea tonsurans on the occipital part of the head. He had been at St. Bartholomew's Hospital for sixteen weeks, undergoing several operations, the final one being amputation of the arm at the shoulder for tuberculosis. He left that hospital in December, and a week or two afterwards he observed a rough patch, with loss of hair, on the back of his head. The patient stated that a week afterwards his little girl (also shown at the meeting) developed a similar patch on her head. Hairs from the man's patch exhibited an abundance of trichophyton megalosporon endothrix. The large-spored variety was also present in the medical student, and probably in the others. In the medical student there was a good deal of mycelium. Dr. Abraham exhibited under the microscope some hairs from the man's head. He suggested that possibly the fungus had been able to

flourish in the man's scalp in consequence of the altered nutrition of his tissues, for he had been much run down in health owing to the operations and the disease which made them necessary. There must be some peculiar resistance of the soil to account for the rarity of the condition in the adult scalp.

Dr. WIGHTWICK said he remembered having a case of the disease in a butcher, who had been attending a calf with ringworm. The man had two or three patches on his head, and others over his body.

The PRESIDENT said there was no doubt about the occurrence of such cases in the adult; most of those who had had a long experience of ringworm had seen them. But probably the number of instances seen by any one individual could be counted on the fingers of one hand. An interesting point was that since attention had been called to the different varieties of ringworm, all the cases had been found to be of the large spore variety in adults. They knew it was not the constitutional condition nor the age of the patient which determined such cases, because ringworm of the beard was seen frequently enough, although there also it was of the large spore variety and of the ectothrix species. There must, therefore, be something in the anatomy of the hair and its follicle, which changed in adult life, and favoured, or did not favour, the development of the ringworm fungus. The hair of the beard was very different in texture and quality to that of the scalp, and that might account for the greater frequency of ringworm in the beard. Sometimes adults attending children with ringworm developed patches of Alopecia areata. At the present time he had under care a child with ringworm of the microsporon variety, and his nurse developed a patch the size of a sixpence, indistinguishable from ordinary Alopecia areata, with "note of exclamation hairs." He had seen half a dozen similar instances. One would like to know whether Sabouraud was right when he stated that adult ringworm was always of the large spore variety. That kind was very much less common in England than abroad.

Mr. PERNET said he had examined a number of cases attending Dr. Crocker's Skin Clinic at University College Hospital.* Only 4 per cent. of the Tinea tonsurans cases were large spored. During the whole period covered by the investigation, and for some time previously, there had not been a single case of ringworm of the scalp in the adult.

Dr. EDDOWES said he could remember two cases of ringworm of the scalp in adults. One was in a woman who was bringing her grandchild to Shadwell. She had quite a typical patch, but as it occurred many years ago of course he did not know whether it was of the large or of the small variety of fungus.

Mr. FREEMAN showed (1) a young woman, a nurse, with two small lesions on her face, one of which had been in existence about fifteen years and the other about eight years. They were slowly increasing in size, and spreading at the outer margin. Recently a new spot had appeared over the left eye. He showed the case before the Society a

* Pernet, "One Hundred and Thirty Cases of Ringworm observed in the Skin Dep. of Univ. Coll. Hosp.," *Lancet*, October 1, 1898, p. 868.

year ago, and some years previously she had been shown before the Dermatological Society of London by Mr. Malcolm Morris. On the latter occasion a good deal of doubt was expressed as to the nature of the affection, and he would now be glad to hear the opinions of members on it.

Dr. EDDOWES remembered seeing the case before, and, as specific disease was such an imitator of everything, he had suggested that iodide of potassium and mercury might be tried. As an alternative, one had to think of some obscure form of tuberculosis. He hardly believed it was rodent ulcer. He thought there was a destructive process going on in the follicles, leading to one follicle after another giving way and leaving a cicatrix. If it were rodent ulcer he would expect to find a more marked edge and a centre deeper by this time. Many years ago, however, he had a patient with what he thought was going to be rodent ulcer, but instead of undergoing the process ordinarily pursued by that malady, the lesion divided into two kidney-shaped halves after running a very slow course; and in that condition the case still remained to the present time, with very little destruction of the skin in between.

Mr. ARTHUR SHILLITOE asked whether the case had ever had chicken-pox, suggesting that it might be a keloid occurring in a chicken-pox scar.

The PRESIDENT said that, in regard to syphilis, the long duration and exceedingly slow process would refute that. Neither did it suggest to him tuberculosis. At the same time it was not exactly like anything he had ever seen before. The nearest condition he thought was rodent ulcer, though rodent ulcer of such long standing without ulceration was somewhat anomalous. Still the present was an anomalous case, and they did sometimes meet with ulcers which were very superficial, and with edges as slightly raised as that. It was strange that there had been no ulceration at any time in its course, but there was atrophic scarring and a process of involution, though he understood it had never been a sore at any time. One would like to examine the lesion microscopically, without which nothing very positive could be said. If it were true that three such spots had occurred, that fact would be against rodent ulcer, as a multiplicity was very exceptional, and when they had an exception added to an exception the rodent ulcer theory would practically be negatived.

Mr. PERNET said when the case was brought before the Society twelve months ago he had taken the view that it was an unusual form of rodent ulcer, and he still held to that opinion. The duration was against the lesion being a syphilitic one.

Dr. EDDOWES said that he could see, through a lens, two or three little points, which looked like a suspicion of pus scattered in the spreading border. He suggested these points might be pricked and the contents squeezed out and examined.

Mr. FREEMAN, in reply, said the patient had never had chicken-pox. He would do what he could in the direction suggested by Dr. Eddowes.

(2) A woman, advanced in years, the subject of almost universal *Leucomelanodermia*, which had existed for about six months. It was accompanied by a good deal of itching. It was chiefly on the chest,

abdomen, back, and buttocks; but she had one or two patches on the legs, especially in the popliteal spaces. She had not been taking any drugs that would account for the condition.

The PRESIDENT said that on the face of it the case looked like melanodermia, but there was a certain amount of change in the texture of the skin, whereas in melanodermia there was no change in texture, so far as could be ascertained, except for the pigmentation. There was, however, one disease in which pigmentation and epidermic change did occur, with thickening of the superficial layers of the skin—namely, that which had been called—not very happily—Acanthosis nigricans. On the other hand, it by no means resembled the case before them in every way. In the patient there was a little epidermic thickening; she had a wartiness on the abdomen, but elderly persons so often had that condition that its presence could not count for much. Again, the patient's axillæ were perfectly free from warty development, and were pigmentless. In Acanthosis nigricans there was great hypertrophy of the skin of the axilla, so that it was converted into warty folds. The neck of the patient, however, was suggestive of that condition. If it were Acanthosis nigricans, they would expect to find it intensified in the groins, which inquiry showed was not the case here. Still, the disease was a very rare one, and they did not yet know all its possibilities. He had at the present time a case under his care in which there was a great deal of wartiness, but scarcely any pigmentation. On the other hand, they might meet with a case with a great deal of pigmentation and very little wartiness, but in those cases the mouth was generally affected. Therefore, on the whole, though Acanthosis nigricans was to be thought of, especially as it was often associated with visceral carcinoma, he did not think they were justified in saying more than that it was an unusual form of leuco- and melanodermia. It would be advisable to watch for any development of visceral carcinoma.

Dr. WIGHTWICK asked how long the case had been under observation, and whether the pigmented areas appeared first and the white patches developed subsequently in these areas, or whether the white patches were areas of skin left untouched by the deposit of pigment?

Dr. BOWLES asked whether the condition was seen to start from one point, or whether it was generalized when first noticed.

Mr. FREEMAN, in reply, said that, almost from the commencement of the condition six months ago, it spread rapidly. He only saw her a fortnight ago. The pigmented portion appeared first. He could not say whether it started from a particular point, or was generalized from the commencement.

(3) A woman the subject of *Senile Warts*.

The PRESIDENT showed a young woman with two rings, about 2 inches in diameter, one in the popliteal space and the other a little further back, on the under surface of the thigh. There was a brownish-red, slightly raised border, and in the centre was a faint atrophic scarring. She also had similar lesions, but of smaller size, on the left arm. The history was that the areas had been developing

about six months. The patient had travelled about a good deal, and two years ago was in India for fourteen months. He took the case to be a very mild form of leprosy. There was as yet very little of it; there was also a lesion on the buttock, which they had not seen. The only two diseases which would occur to them were syphilis and leprosy. It was not quite like syphilis, and there was the history of the stay in India which he had mentioned. There was the circular character of the lesions, which spread peripherally, with atrophic scarring, which was very suggestive of leprosy. It was the kind of lesion he had seen several times, but always of the very mildest form, and generally associated with the nerve form of leprosy rather than with the nodular form. As a rule there was more or less anæsthesia in the centre of the patches, and he believed it was present in this patient; but she was neurotic, and her answers to inquiry whether she felt a pin prick in different parts were so much at random that he could not demonstrate it. Still, he believed there was diminution of sensibility to pain. The case was interesting as showing the extremely mild form in which leprosy might appear. He thought it was one of the greatest arguments against the suggestion which had been advanced that all lepers should be segregated. No doubt in countries where it had been rife, as for instance Norway, segregation had reduced the spread of the disease; but to segregate every patient in such a country as England would be an act of cruelty for which there was no justification whatever. After all, leprosy, even in its most aggravated forms, was a very feebly contagious disease, not much more so, as a rule, than cases of advanced phthisis, except that no one would become inoculated with a leprous sore if he could avoid it. Nevertheless, such inoculations had been made purposely, but had failed.

Dr. Stowers sent a case of *Lichen spinulosus*, the patient being a female 32 years of age. The eruption was very well marked when seen by Dr. Stowers at hospital a week ago, and as yet no local treatment had been adopted. It was stated to have commenced in July, 1898, between the breasts, and to have gradually developed. At present it involved in a roughly symmetrical manner the upper part of the chest in front, upon and between the breasts; behind, there was a large space between the scapulæ quite

free, but a circular arrangement of spinous papules around that area existed. Considerable itching was complained of. He believed it to be a well-marked example of Lichen pilaris or Lichen spinulosus, terms used to signify the same condition.

The PRESIDENT thought it an unusually marked example of the disease. The interesting point was that the same condition sometimes occurred as a complication of two other affections, called Lichen scrofulosorum and miliary Syphilide. The latter was like Lichen spinulosus morphologically, or it might occur as a separate affection, as in the present case.

Dr. EDDOWES showed a case of *Folliculitis necrotica*, the patient being the third subject of the condition he had encountered. He agreed with Brocq, of Paris, in looking upon the affection as a distinct disease. Although it in some ways resembled acne, yet the recurrence of the lesions was exactly the same time after time and characteristic. The mouth of a follicle became slightly reddened, and it looked as if there were a trace of exudation, then a little crust formed on it, like a flat bell. This crust remained until it was usually scratched off. Whether scratched off or not, it apparently always left a slight scar involving the mouth of the follicle particularly, and sometimes one or two of its neighbours. Generally, however, it seemed to be limited to one or two follicles at a time. The whole of the patient's back was becoming scarred. He had had the disease eight or nine years, and although it was easy to make him better by remedies, as soon as those remedies were left off the condition returned. He was always worse if he caught cold. He had seldom seen any pustules in any of the cases, and few comedones. Apparently its distribution was from the nape of the neck to the waist. This patient had had some of the lesions on the chest, but they were almost entirely confined to the back. The crust he had mentioned was yellow, and slightly friable. It adhered firmly, but the irritation generally caused it to be torn off. Brocq stated that it was extremely intractable, and there was no doubt that it was much more difficult to treat than ordinary acne.

Mr. PERNET remarked on the resemblance of some of the lesions to those of Acne varioliformis.

The PRESIDENT thought they must agree with Dr. Eddowes that it was a separate clinical form of disease, and thought it resembled, but did not come under the category of, Acne varioliformis.

Dr. EDDOWES, in reply, said he thought it was very important to recognize the disease, so that we might give a guarded prognosis as to the result of our treatment.

Wednesday, March 22nd, 1899.

A Meeting of the Society was held on Wednesday, March 22nd, Dr. H. RADCLIFFE-CROCKER in the Chair.

CLINICAL CASES.

Dr. SAVILL brought a case for diagnosis. The patient was a woman, æt. 53, with a very extensive eruption all over the body and limbs, which had started three months before on the right wrist. It then involved the arm, and gradually became general. The elements of the eruption consisted of flat purple papules, of a very characteristic polygonal shape, and covered with a whitish silvery scale in certain places. There was a certain amount of symmetry in its distribution. The subjective sensations were not prominent, but itching sometimes occurred when she got warm in bed. On the whole, he considered that the evidence was in favour of the condition being an example of *Lichen planus*. The lesions on the legs were verrucose in character. On the arms the distribution was glove-like from the fusion of the elements together. The only feature wanting was the depression of the centres of the papules. There was also some evidence of the condition on the pillars of the fauces. The patient had been treated with arsenic for some time.

Dr. STOWERS corroborated Dr. Savill's opinion, and emphasized the importance of examining the whole surface and all the lesions in cases of this character.

Dr. EDDOWES remarked that this case recalled a patient formerly shown by him to the Society, and who was still under his observation. In his case the lesions were confluent on the neck and upper part of the trunk, and discrete on the arms. The condition of Dr. Savill's case somewhat resembled Unna's so-called Parakeratosis variegata.

Dr. PHILLIPS-CONN remarked on the importance of observing the lesions on the buccal mucous membrane, and considered that this was an important diagnostic feature between Lichen planus and certain papular syphilides.

The PRESIDENT said the case presented an unusual feature. He and Mr. Pernet noticed that the patient had a bulla on the front of her thigh. The occurrence of bullæ in relation to Lichen planus was a phenomenon the occurrence of which was known, but it was very rare. He had often been puzzled as to how far the administration of arsenic might determine this condition, or whether it was entirely

a symptom of Lichen planus. He had never seen bullæ in a case of Lichen planus which had not been treated with arsenic.

Dr. Stowers showed a case of Sclerodermia, the patient being a married woman, æt. 36, with one child. Her father was living and well; her mother died of bronchitis at the age of 58. The patient had never had any severe illness. Seven or eight months ago she discovered a circular whitening of the skin, about the size of half-a-crown, on the upper surface of the right thigh. Four months later she noticed a longitudinal patch of whitened skin on the flexor aspect of the left forearm, two inches long and one inch broad. At the same time, on the extensor surface of the same limb, an oval patch of larger size was noticed. This had spread slowly and irregularly since, in an upward direction. During the last four weeks a circular patch (1 in. by ¾ in.) had appeared on the flexor surface of the left upper arm, the long diameter corresponding with the axis of the limb. In a roughly symmetrical manner similar patches had appeared on the right arm and forearm, though to a less marked degree. On the anterior surface of each thigh a patch was visible, of the size of a shilling. There were also five circular patches on the back—three in or near the middle line, and two over the right scapula. Another, less marked and circular, existed over the sacrum. On the anterior surface of the chest she had two circular patches of the same kind to the right of the middle line; and one upon the scalp, over the occipital bone. All the areas were painless, and presented the usual ivory appearances of localized sclerodermia or morphœa, with its other characteristics. Round some of the patches there was a pink halo. The symmetry of the affection was particularly interesting.

Dr. Galloway said that he was glad to have the opportunity of seeing Dr. Stowers's case again. In reference to the pathological changes in the disease, he took the opportunity of mentioning that he had recently had the opportunity of examining thoroughly, with his colleague Dr. Mott, the lesions in the case of a woman who died after having had sclerodermia for some years. The lesions had been mistaken for scars from burning. Dr. Mott had been unable, in spite of very careful examination, to discover any lesions in the central nervous system, in the peripheral nerves, or in the posterior root ganglia, to account for the sclerodermic lesions, or corresponding to them in situation. He had himself examined the skin, and found the changes described by other observers. In regard to the peripheral nerve terminations, he was unable to make any statement, the result he had obtained being quite negative. He hoped to describe this case in more detail on some future occasion. In spite of the negative observations in this case, he felt

that the disease was due to nerve changes, and referred to the remarkable enophthalmos occasionally seen in cases of supra-orbital sclerodermia.

Dr. SAVILL said he was interested in seeing Dr. Stowers's case and hearing Dr. Galloway's remarks, as he (Dr. Savill) showed a case of sclerodermia before the Society recently, where there were, at least, two distinct evidences of the nervous system being involved. One was the occurrence of muscular atrophy, which may have been an accidental concurrence. The other was a lesion commencing as a vesicle on the end of the third toe of the right foot, and causing sloughing of the skin, and cicatrization. He was sorry the search for the lesion in Dr. Galloway's case had been unsuccessful, but he thought that, on clinical grounds, the evidence pointed more in the direction of a lesion of the nervous system than in any other. The chief difficulty, in his mind, was as to which part of the nervous system, but he would certainly look to the grey matter around the central canal of the cord. On one occasion he examined a case, post-mortem, of syringomyelia, in which there were changes in the skin bearing a very striking resemblance to sclerodermia. He would like to know whether Dr. Stowers had tested the temperature sense, particularly around the patches. As to treatment, his case owed its recovery a good deal to the administration of thyroid extract.

Dr. EDDOWES remarked on the resemblance of the patch on the scalp to Alopecia areata. He had recently seen a patient whose scalp was absolutely free from any sign of hair, or even down. He was a young, strong-looking man. He had brown patches on his head, which were being encroached upon by the white parts of the scalp. When undressed he was found to be piebald, and there was marked leucodermia, increasing by a red margin. Around the genitals he was almost black. On several parts of his body he had well-marked morphœa or sclerodermia, and he said that some other parts of his body had been as "hard as a board."

The PRESIDENT said that, *a priori*, he would expect that if there were nerve changes they would be more likely to occur in the periphery, though in a generalised case they might be in the nerve centres. There was very little evidence of the purely nervous origin of any skin disease, except perhaps bullous eruptions and herpes. But what was the relationship in such cases it was very difficult to follow. They might take it that if Dr. Mott found no change in the cord there was none present.

Dr. STOWERS, in reply, referred to the drawings of a case of very advanced generalised sclerodermia in a female patient which were shown originally at the International Dermatological Congress of 1881. The appearances bore out exactly those described by Dr. Galloway. It was of twenty years' duration, and so marked were the contractions about the hands, besides the crippling of her body generally, that the nails were drawn up on to the distal end of the first phalanges, absorption from pressure of the other two phalanges being almost complete in every instance. There was also remarkable enophthalmos. Dr. Stowers hoped to be able to test the local temperature sense as suggested in this case by Dr. Savill. The patient had not been under treatment; and she had only been under observation for a fortnight.

Dr. EDDOWES showed a case of *Lichen planus* in a boy 4½ years of age. Yet he had, so to speak, an adult condition of Lichen planus.

He was operated on for growths in the nose on December 2nd last, and he had measles 15 months ago. He was said to be a nervous child. The rash began a week after the nasal operation. These were buccal lesions.

The PRESIDENT said it was uncommon to have Lichen planus so well developed in such a young patient. He had seen it in younger patients, but not so highly developed.

Dr. ABRAHAM showed (1) two cases of *Dermatitis herpetiformis*. One of them had been shown to the Society in May, 1897, when the man had crops of vesicles arranged in a herpetiform manner. They commenced as little bullæ, with erythematous bases, and left scars many of which could be seen on the lower part of his back. Since then he had had several recurrences, and they had come out in different forms, which Duhring looked upon as characteristic of the disease. He had had severe crops of boils, and at the present time the bullæ which had come out were purulent. He had been under Dr. Abraham's care for two years; when he got well he disappeared for a time, and only presented himself again when he had a recurrence. Thyroid gland benefited him for some time, and it was under that treatment that his first attack disappeared.

With regard to the second case, which differed very much from the other, when he first saw the lesions, the fact that they were localised on the forearms, and that there was extensive scarring, led him to think, at first, that it was one of tertiary syphilis, but the man stated the scars were the result of burning, that he had been scalded all over in early youth. He (Dr. Abraham) had not much doubt as to the diagnosis, viz.: Dermatitis herpetiformis. The question arose whether the nutrition of the skin being interfered with over the scar tissue had anything to do with the localisation of the bullæ over those areas. The condition almost disappeared a short time ago, but had since recurred. When the eruption occurred, the man was very much out of health, and that was Dr. Abraham's experience in some other cases of this kind. The last case of Dermatitis herpetiformis he exhibited to the Society had had a very severe kidney affection for some time previously. That man got perfectly well, but three weeks ago the lesions reappeared.

Dr. TRAVERS SMITH said that a fortnight ago he saw a boy whose case had been

reported in the *Lancet* of April 30th of last year. Four years previously he had got burnt on the chest, and last year he had what was described as Herpes zoster; a vesicular eruption, which was almost limited to the scar of the burn which spread over the left half of the thorax and a portion of the right side in front. The mother of the boy pointed to red spots lying here and there over the blanched scar as the effect of the vesicular eruption.

The PRESIDENT said the first case was certainly very typical in its distribution as well as in its arrangement. As was so frequently seen in this disease, it was specially marked about the axillæ, shoulders and groin. The second case might be open to discussion; there was so much eruption that it was very difficult to make a distinct diagnosis. Still, Dr. Abraham had probably watched the affection develop, and had been able to notice whether there was distinct grouping when the lesions came out. Probably the burn had a determining effect, but sometimes Dermatitis herpetiformis was limited,—he had seen it restricted to the hands or to the axillæ for a long time. Perhaps Dr. Abraham would tell them whether there were any erythematous lesions in connection with the vesicular lesions. He presumed the second case had not had any thyroid extract.

Dr. ABRAHAM, in reply, said he thought the older man had had no thyroid extract, but he had been treated with arsenic. With regard to the erythema, when he first came there were distinct patches of erythema on his arms, with bullæ in the centre.

(2) A case of probable *Bazin's disease*, in a girl of 13, and a *localised congestion* of the nose in a little boy of 7, the patients being brother and sister. The girl had what he took to be Bazin's "Érythème induré des scrofuleux," and the boy had persistent erythema and coldness of the nose, which had lasted for four years. The condition was very much worse in the winter. He could find no lupus or apple jelly growth. The mother told him that the nose sometimes got rather pale, but in the cold weather it became very red and cold. The girl had had mottling and erythema of her legs ever since infancy. It had got very much worse since an attack of measles when 5 years old—*i.e.*, eight years ago. During the last year or two the legs had become very painful, and there was distinct thickening of the skin in parts; there had been some ulceration, though not since the case had been under his care. She also had thick clubbed fingers. Nothing definite could be found wrong with the heart. The mother's family was distinctly tuberculous, several members having died of consumption. He had not examined the boy's heart.

Dr. GALLOWAY said that he did not feel inclined to criticize Dr. Abraham's diagnosis in the case of the girl, provided they defined their position. He thought that at the present time they were in a very considerable difficulty regarding the

diagnosis of the condition, because apparently at least two conditions are being described in the ordinary dermatological literature under the name Erythema induratum. One was a disease in which distinct nodules occurred, with an infiltration of the cutis, breaking down and giving rise to ulcers, frequently with serpiginous margins. The other was the state of which the case before them was a pure example, in which the lesion was really œdema of the cutis, associated with paralytic distension of the superficial vessels. The ulceration which came on under those circumstances was due simply to the fact that the skin was so œdematous and so badly nourished, and the circulation carried on with such difficulty that a very slight injury was capable of producing an ulcer which would not heal readily, but went on spreading usually to a considerable extent. He thought there was œdema of the skin rather than inflammatory infiltration. At Charing Cross Hospital he had under care an extraordinary example of disease related to that type, the patient being what they might appropriately call a "red girl." The circulation was carried on with difficulty, and there was striking tachycardia, the pulse being rarely under 120 or 130; often still more frequent. The circulation was under very low pressure, and the whole of the superficial parts of the body were always œdematous. If she knocked her leg against a chair she had a bruise, which broke down, and an ulcer formed which took three to five months to heal. Dr. Abraham's patient was all the more interesting when considered with that of the brother, the latter also suffering from circulatory feebleness. If any change occurred in the nose it need not be of the character of Lupus erythematosus, but all would agree in acknowledging the close relation of Lupus erythematosus to circulatory weakness of this character. They were apt to get into trouble in distinguishing between these two conditions, both of which were described as Erythema induratum.

Dr. Savill said he had listened very attentively to the latter part of Dr. Galloway's remarks. All Dr. Galloway had said exactly coincided with his own ideas. There were, he thought, two distinct conditions to which the name Bazin's disease had been applied; one with distinct subdermal nodules, the other with only patches of congestion. In both there was a general solid œdema. He thought that the second case hardly came within the definition of true Bazin's disease. Only on the inner surface of the right leg could any induration be felt that could be called a localised dermal or subdermal nodule, such as one expected to find in Bazin's disease. In this case there was a general hypostasis and thickening of the skin. He had been in the habit of calling such cases, for his own information, "Erythema induratum hypostaticum," as distinct from the Erythema induratum scrofulosorum of Bazin. A similar condition was not infrequently met with in adults who were the subjects of bronchitis and dilated right heart. There was, in such cases, a great tendency to intractable ulceration and sometimes necrosis. He considered Bazin's disease to be essentially tubercular.

Dr. Rufenacht Walters said he had hoped to have brought a case which would have illustrated Dr. Galloway's remarks—viz., a case of Lupus erythematosus. The first patches appeared on the cheeks. There were also some curious conditions of the upper extremities, reminding one of Raynaud's disease; and now, some months later, the disease had spread considerably, and there were patches of Lupus erythematosus, not only covering the face, but also on parts of both the upper and the lower limbs. The condition of the lower limbs of that patient reminded him of the one in this girl.

The PRESIDENT was inclined to agree with Dr. Galloway, that the case did not come into the category of typical Erythema induratum, but that it was more a consequence of deficiencies in the circulation. More than one condition would produce those indurated swellings on the calves, which were so closely associated with Bazin's disease; but they were unable to go so far as Dr. Savill, and say that true Bazin's disease was undoubtedly tuberculous; proof so far was still lacking, even though Bazin himself called it Erythema induratum scrofulosorum. He (the President) thought the two cases should be taken together. The boy's red nose was probably due entirely to feeble circulation in the extremities, and he thought there was a very good chance that he might never get beyond that for the remainder of his days. A nose with such a feeble circulation was more vulnerable to inflammatory action than a normal one would be.

Dr. ABRAHAM believed the girl's case came under the category first described by Bazin. As every speaker had admitted, the girl was of a scrofulous tendency. He agreed with Dr. Galloway in what he said about the want of precision in the diagnosis of these cases, for possibly syphilitic cases were sometimes included among cases of Bazin's disease, as well as ulcerated tuberculous spots occurring on the legs. A few years ago, some of the best authorities in England called these cases of Bazin congenital syphilis—an error, I believe, first rectified by Dr. Colcott Fox. In both the cases now shown he thought the circulation was at fault; and, indeed, he had at first noted them down as "localised asphyxia of the skin." He subsequently, however, came to the conclusion that the girl's was really an instance of Bazin's original affection.

Dr. TRAVERS SMITH brought forward the case of a young woman presenting a cluster of red, nearly coalescing, papules on the malar portion of the left cheek; scarring of the outer border of the helices of both ears, and indurated papules on the dorsal aspect of the fingers of the left hand. Last Christmas she had fallen against the edge of a marble washstand, and put some arnica over the bruised part. Three weeks afterwards she noticed the appearance of the papules. On her left hand the lesions, which looked like chilblains—(?) indurated papules—were synchronous with the affection of the ears, which she described as commencing as "hard lumps," which were very itchy. The mother was rheumatic, and a brother was stated to have died of tuberculosis of the kidneys. It was suggested that it was a case of *Lupus erythematosus*.

Dr. SAVILL agreed with Dr. Travers Smith's diagnosis, and drew attention to the lesions on the hands; in his opinion the lesions on this situation frequently appeared during summer-time.

Mr. PERNET thought there was no doubt that the case was one of Lupus erythematosus.

Dr. STOWERS considered Dr. Travers Smith's case to be one of erythematous Lupus. He would not be inclined to connect it with the alleged injury. He wished

to obtain the opinion of members of the Society as to treatment. He considered linear scarification as a very valuable method of treatment in appropriate cases, and when used with knowledge. The scar so produced was less than that left by the disease when it was permitted to run its own course. He wished to ascertain the grounds on which the use of this special form of treatment was to be recommended.

The PRESIDENT was of opinion that the whole condition was that of Lupus erythematosus. The disease tended to attack the extremities and those parts where the circulation was weakest. He had frequently seen lesions looking like chilblains, which had been called by Mr. Hutchinson Lupus pernio. With regard to the patch on the cheek, he agreed with Dr. Stowers that it had nothing to do with the injury; but given a patient who was disposed towards Lupus erythematosus, an irritant like the blow was extremely likely to excite the condition at the point at which it was applied. He considered that arnica caused many more rashes than it cured. He agreed with Dr. Stowers that scarification in Lupus erythematosus was valuable, but before trying it on such a simple-looking patch as that, he would use very mild treatment perseveringly, such as the application of a simple lotion like calamine lotion. If, after such application, one part seemed more persistent than another, then multiple scarification might be tried. Where there was only simple erythema, a soothing astringent lotion and protection against cold winds would be sufficient of itself to clear up a large part of the disease.

Thursday, April 27th, 1899.

An ordinary meeting was held on April 27th, 1899, Dr. RADCLIFFE-CROCKER, President, being in the chair.

CLINICAL CASES.

Dr. RADCLIFFE-CROCKER showed an unmarried woman, æt. 48. Ten years ago she was a servant. The present condition started six years ago, and about three years after diphtheria. Three years ago she was free from any lesion for a period of three months. She had been supported by charity for the last three years. The lesions were of an erythematous and bullous character, and some of them had left scars. They came out one or two at a time, and were situated, to a large extent, over the abdomen and left limbs, and she had a constant succession of them, which could be seen in various stages. The President said that the conclusion he had come to was that the eruption was self-induced. It would be noticed that all the lesions were on the front of the body; most were on the left side; and there were none on the right arm. In some cases their outline was very angular, and the lesions did not correspond with any known natural eruption. The patient had, perhaps, been a victim of too much charity on the part of the "lady-bountifuls" of the district. There were some grounds for believing that the lesions were produced by mustard, but that was not definitely proved, as she had only been under observation for a short time.

Dr. RUFENACHT WALTERS showed a married woman, æt. 42, living at Islington. She first consulted him at the City Dispensary, on March 15th, 1899, complaining of weakness and pains in the head. There were some dyspeptic symptoms, and a little anæmia, but no rash. The bowels were constipated, the appetite fair, the tongue pale and clean. The heart was hypertrophied, with a double murmur at the base and apex. The urine was pale and clear, with some albumen, but no sugar. She was treated for a day or two with an

aperient chalybeate mixture, and for the pain in the head 10 grains of antipyrin three times a day, on March 29th. On March 31st she perspired freely, vomited her food, and was covered with an extensive scarlet-measly rash, which she described as looking like small boils, which, on April 5th, were seen to be erythematous and papular. On April 19th some of the spots were slightly scaly, and some near the shoulders were ringed. The medicine had been changed on April 5th to an alkaline mixture, and on April 19th she was treated externally with ung. hydrarg. ammon. The rash was said to have begun at the bends of the elbows and about the knees. It now affected the limbs over a considerable area, chiefly on the flexor aspect and near the bend of the elbows; also the axillæ, shoulders, and back; and the chest and legs slightly. It consisted partly of small papules, partly of confluent patches of papules with crescentic or circinate border, partly of rings with slightly raised edges. There was no evidence of fluid exudation beyond very slight scales. The scalp appeared to be free, and unaffected with pityriasis. The skin was not noticeably stained, nor was there scarring, or permanent thickening, or atrophy of the skin beyond that described. The spots were grouped in patches. There was much irritation, but not much burning, and few or no scratch-marks. There was more or less, but not absolute, symmetry. There was no fluid exudation, therefore it was not like ordinary eczema. Its absence from the face and scalp was against its being Eczema seborrhoicum; yet, on the whole, he thought that was the probable diagnosis. Syphilis, he considered, was out of the question. If it had been a medicinal rash from antipyrin he would have expected more discoloration or hæmorrhage; it persisted after the withdrawal of antipyrin.

Dr. WALDO (Bristol) remarked that if the eruption had been on the chest or back he would have diagnosed seborrhœa. He inclined to the view that it was seborrhœa occurring in an unusual position. He ascertained that the patient sweated very much, and the skin was rather greasy.

The PRESIDENT thought the condition was connected more with the sweat-glands than with the sebaceous glands. Probably the antipyrin was the excitant, though it did not determine the form of eruption. Antipyrin rashes were very multiform in appearance, and sometimes localised. He regarded the present case as one of sweat eczema, which simple astringents would benefit.

Dr. TRAVERS SMITH showed a married woman, æt. 28, who had

had for six or seven months what appeared to be *Eczema of the left nipple.* It occurred while suckling her child, when it was three months old, and the consequent bleeding caused her to cease suckling. She had used various ointments, on her own account, such as "Cuticura," cold cream, and so forth. No improvement resulted, and they knew that some malignant forms of dermatitis, such as Paget's disease, commenced in a very inoffensive way. He would be glad of the opinions of members, and hints as to treatment.

The general opinion expressed was against the disease being of the malignant type.

The PRESIDENT thought it certainly was not a malignant condition at present. The patient was very young, there was a total absence of real induration, and until one found some induration, however slight, a diagnosis of malignancy was not justifiable. When such a diagnosis was established the treatment was so radical that it was necessary to be positive. At present every other resource should be tried. As a rule he did not believe there was a family history of cancer in cases of Paget's disease; they were not on all-fours with scirrhous carcinoma or epithelioma, but were more allied to rodent ulcer, and might persist for years without implicating the breast itself to any extent. Some thought such cases were carcinomatous from the first, but he was of opinion that such was not always the case. Paget's disease was really not like eczema, but had the appearance of a punched-out shallow ulcer, which might be crusted over, and when the crusts were removed there was a distinct loss of substance, and at the same time there was induration. Eczema of the nipple was a misnomer, and until they were satisfied as to the true pathology it would be better to adhere to the term Paget's disease. He hoped Dr. Travers Smith would report the case again in a month or so.

CLINICAL NOTE.

Dr. MOUILLOT (Harrogate) communicated particulars of a case of *Arnica dermatitis.* He gathered that severe cases of Arnica dermatitis were extremely rare. The President, in his book, had stated that such cases were fairly common when arnica was more used than at present as a household remedy. He (Dr. Mouillot) believed it was still largely used, and the warning in his communication was that it should not be used by medical men.

A young gentleman, æt. 20, intended going on a walking tour, and was advised by the friend who was to accompany him that if he rubbed tincture of arnica into his feet he would stand the walking very much better. He thereupon procured some, poured it into the palm of his hand, and rubbed it upon the soles of his feet. Early the following morning he was awakened by intense pain in the feet, and at noon on the following day Dr. Mouillot was sent for. He found the feet swollen

and covered with small papules; his temperature was 101·5°, and he was evidently in great distress. Within forty-eight hours of the application, vesicles and bullæ appeared, as could be seen by the photograph, some as large as a walnut. His hand was also affected, as well as the mouth, which he had evidently touched with the hand while in bed. He ascertained, that seven years previously, a similar but slighter manifestation attended the application of arnica to a bruise. The patient had to remain in bed a fortnight. He got quite well, and there was no thickening of the bone or other sign left. He had never seen so severe an eruption from such a simple cause.

Dr. Bowles said he had observed several cases of inflammation due to the application of arnica. He thought such cases were once commoner than now. One patient years ago gave him great anxiety. A gentleman met with an accident in the hunting-field and injured his knee. He enveloped it in strong arnica lotion, and was so confident that it would do good that he (Dr. Bowles) permitted it. Two days later the knee was very much inflamed, there was some effusion into the joint, and the patient was in great pain. There was an eruption similar to that described by Dr. Mouillot, and an inflammatory thickening of the skin. He did not know how far to attribute the condition to the injury and how far to the arnica. This acute condition lasted for a week or nine days without any fresh applications, and was followed by stiffness of the joint, which he attributed to the external inflammation rather than to the original injury. The joint afterwards became fixed, and remained so for life. Surgeons had been unable to find any evidence of dislocation; but only of universal adhesions. Abroad arnica was used both inside and out, and Dr. Bowles related a case of injury at the French manœuvres where, after considerable difficulty, he had prevented its internal use. He mentioned these matters to protest against the indiscriminate use of arnica.

Dr. Dale James (visitor) mentioned a similar case to that related by Dr. Mouillot in a professional runner, who applied it to the inside of his thighs after running, with very serious results indeed. His scrotum, penis and insides of his thighs were inflamed, and he was in bed for three weeks, but eventually recovered.

The President said such extreme cases were rare. The inflammation was not always limited to the point at which the arnica was applied, and sometimes became a generalized dermatitis. Such cases could be diagnosed from eczema when severe, but not always when of slight degree.

Dr. Mouillot, in reply, thought the interest of his case was that there was no abrasion of the surface, and that the bullæ came out even in such tissue as that in the sole of the feet, and in a man who took much exercise. In this patient, when he had the eruption at school, the medical attendant to the school diagnosed an herpetic eruption, and did not think the arnica was a causal agent.

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